ZdravReform Regional Technical Conference Report

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Prepared by:
Marty Makinen, PhD
with assistance from Barbara Burgess

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ZDRAV*REFORM* PROGRAM
REGIONAL TECHNICAL CONFERENCE REPORT

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INTRODUCTION

The Zdrav*Reform* Regional Technical Conference, held December 14-15, 1995 in Almaty, Kazakstan, disseminated information about Program progress and lessons learned and provided an opportunity for cross-fertilization of ideas among professionals who are engaged in health reform and from the countries of the New Independent States (NIS). More than 50 papers on various aspects of financing, management, and organization reforms were presented to an audience of 213, including more than 160 practitioners of reform from Kazakstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan, and personnel from international assistance organizations.

The U.S. Agency for International Development (AID) created the Zdrav*Reform* Program in late 1993 to assist with financing, management, and organization initiatives in the health services sector in the NIS. Abt Associates Inc. executes the Zdrav*Reform* Program contract. Zdrav*Reform* collaborates with national and local government officials, policymakers, managers, and providers of health services to design, implement, and evaluate initiatives aimed at improving financial sustainability, efficiency, and quality of care, while preserving equitable access. This collaboration takes the form of technical assistance, training, information dissemination, and grant support.

The papers presented at the Conference covered a broad array of reform initiatives in various stages of execution. This permitted Conference participants to maximize learning about what has worked, what obstacles have been encountered and whether and how they have been overcome. and what ideas have been proposed but are yet to be implemented. Much cross-fertilization took place, since different countries and localities are trying different approaches to similar problems or are at different stages of execution. In addition to the Conference's three plenaries and fifteen concurrent sessions, participants took full advantage of the time reserved between sessions for informal discussions. Two evening receptions held in conjunction with the Conference facilitated informal meetings, as well.

[1]The authors wish to acknowledge the contributions made to this report by those who provided the notes they took at the Conference, Sheila O'Dougherty, Victor Omelchenko, Marc Stone, Nancy Pielemeier, John Stevens, Borys Uspensky, Lonna Milburn, Charles Krakoff, Gary Gaumer, Tom Wittenberg, Linda Moll, and Jack Langenbrunner. The authors also wish to thank Olga and Larisa Gilova and their team for the logistical arrangements at the Conference. Gratitude also is owed to Courtney Roberts for editorial help with the report.

This Conference marked the first time many of the reform practitioners from around the NIS had participated in a voluntary association of health professionals, without central direction, where they were free to exchange technical information and views. Few, if any, of the participants received an official mandate on the content or delivery of their presentations. Establishing the precedent of a professional meeting with open technical exchanges represents an accomplishment in its own right.

The Conference was opened by Kazakstan's Minister of Health, Dr. Vassily R. Deviatko; Deputy Chief of Mission of the U.S. Embassy in Kazakstan, Jane Fort; U.S. Agency for International Development (USAID) Regional Office for Central Asia Deputy Director, Patricia Buckles; Zdrav*Reform* Program Director, Nancy Pielemeier; and Zdrav*Reform* Program Regional Director for Central Asia, Michael Borowitz. Dr. Deviatko emphasized the importance of the issues discussed at the Conference for all NIS countries and noted the universality of market laws. Ms. Fort congratulated the participants for taking on the difficult issues of balancing the provision of social benefits with the burden of financing, noting that a similar challenge faces the U.S. and Western European countries. Ms. Buckles stated that USAID was pleased with the progress made on health reform in Central Asian countries and that USAID-funded training and technical assistance was being put to good use in assisting the countries in achieving this progress. She cited as particular successes the privatization in the pharmaceutical sector in Kazakstan, the health reform demonstration in Issyk-Kul Oblast, Kyrgyzstan, and the increased market orientation in the operation of health facilities throughout Central Asia. Dr. Nancy Pielemeier praised the participants for their health reform accomplishments and recognized that they have been working "double time" to meet the ordinary demands of their jobs while pursuing reforms. Dr. Michael Borowitz called attention to the fact that all of the represented countries' health systems began with common roots, but had begun to diverge with the institution of reforms. He suggested to Central Asian participants that it would be wise to learn lessons from Russia's experience with implementing health insurance.

The Conference was closed by Director of the Mandatory Health Insurance Fund of Kazakstan, Dr. Tokon Imanbaev; USAID Representative, Marilynn Schmidt; Zdrav*Reform* Deputy for Technical Programs, Dr. Marty Makinen; and Drs. Nancy Pielemeier and Michael Borowitz.

The papers presented in the concurrent technical sessions were selected on a competitive basis. Zdra*Reform*'s field offices in Russia, Ukraine, Moldova, Kazakstan, and Kyrgyzstan circulated a call for abstracts, and after technical review papers were selected for presentation based on technical merit, responsiveness to Conference themes, and importance of topics. Generally, priority was given, in the following order, to papers that presented:

- Results of evaluations of reforms in operation
- Descriptions of reforms in operation
- Analyses of the pre-reform situation and descriptions of planned reforms
- Descriptions of the application of new analytical tools

Technical staff from the Zdrav*Reform* headquarters office in Bethesda, Maryland and each of the regional Zdrav*Reform* offices participated in the selection of papers. The themes cited in the call for abstracts and the number of concurrent sessions organized for each (in parentheses) were:

- Protecting Patients, Physicians, and Society Under Health System Reforms (1)
- Concepts of Health Insurance in post-Soviet Societies (3)
- Payment Incentives for Structural Change (2[2])
- Methods and Business Skills for Now and the Future (5)
- Restructuring Health[3] Systems (3)
- Experiments in Primary Health Care (1)

The available abstracts[4] of the papers accepted for presentation are published in a separate volume. The quality of the submitted abstracts determined the distribution of numbers of papers by theme.

Key Note Address

Abt Associates' Program Vice President for Health Gary Gaumer presented the Conference's keynote address, "The Role of Consumers in Health Reform." Mr. Gaumer stated that there are three universal beliefs about the reform of health services systems around the world:

1. Health can be improved if efficiency is improved;
2. Administration costs can be decreased without compromising services;
3. The role of consumers in the system should be elevated.

He noted that an increased role for consumers would mean a loss of traditional administrative control in NIS countries. but could lead to better overall outcomes. Linking the first and third of these universal beliefs, he said that giving consumers the power to "vote with their feet" (have free choice among providers or insurers) and making them financially responsible for their actions, makes them allies in increasing efficiency.

Mr. Gaumer illustrated the power of consumer choice with the example of U.S. experience. In the United States, consumers and the employers who pay for insurance are provoking a revolution in the organization of the health services system, without waiting for national legislative change (such as the failed Clinton health reform initiative of 1994). This movement by consumers and

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[2] A plenary session was conducted on payment methods independent of submitted abstracts.

[3] The original theme in the Conference Call for Abstracts. "Restructuring Hospital Systems," was broadened to include restructuring of national and territorial health systems and restructuring of all types of provider institutions, not just hospitals.

[4] Abstracts for some of the papers presented by Russian authors are not available.

employers is drawing a response from providers and insurers to change the products and services they offer and the way in which they are organized.

Mr. Gaumer stated five lessons from the American experience:

1. An entirely voluntary health insurance system creates problems and should be avoided;
2. Payments by users for services are important to involving the consumer financially;
3. Provider and consumer incentives should be aligned;
4. Focus should be put on consumers' health and wellness, as opposed to illness and cure;
5. Consumers should be permitted to choose their primary care doctor.

Finally, he stated that two of the reform tools available work together like the two blades of scissors. These complementary tools are consumer choice and user payments.

SUMMARY OF TECHNICAL PRESENTATIONS

The following sections summarize the presentations made and subsequent discussions in the concurrent technical sessions. The summaries are organized by theme. Staff chaired each concurrent technical session. The chairpersons introduced the sessions by giving a brief presentation on how the topics to be presented related to one another and to the overall reform process. The chairpersons also summarized the main points made during the session at its conclusion. Finally, the chairpersons took notes during the sessions. The summaries in this report are based largely on those notes.

Protecting Patients, Physicians, and Society Under Health System Reforms

This topic was covered in one sub-session, chaired by Lonna Milburn, Director of Zdrav*Reform's* Office in Novosibirsk, Russia. All three papers presented in the session came from Kazakstan.

The sub-session was designed to address concerns that decentralizing the health sector might jeopardize access to vulnerable groups to adequate health care. Each of the presenters described threats to equity accompanying the introduction of market-oriented systems. They concluded that two complementary changes are needed: linking user payments to a minimum benefits package and resolving regulatory issues in a mixed state and private retail pharmacy sector. Both of the presenters focused on Kazakstan.

Health Economist Jack Langenbrunner of Zdrav*Reform*/Bethesda made a presentation on the results from a household survey in South Kazakstan Oblast. In November 1994, an oblast-wide household survey was conducted to determine people's attitudes towards health reform and the mandatory health insurance program to be introduced January 1996. One of the findings of this survey was that the majority of people already do or are willing to make out-of-pocket payments to receive better care or services, including laundry services, bedding changes, pharmaceuticals, and, even, doctor's care. Despite legal prohibitions, out-of-pocket payments are common throughout the former Soviet Union. Therefore, the lessons learned in South Kazakstan may be

applicable elsewhere. It is hoped that user charges will be linked to the benefits packages developed under Kazakstan's newly introduced mandatory health insurance program.

Charles Krakoff, Pharmaceutical Privatization Advisor in Zdrav*Reform's* Almaty office, made a presentation on the effects of privatization of the pharmaceutical market on behalf of Tarbiyay Sarabekova of the Small-Scale Privatization Department of the State Property Committee of Kazakstan. Farmatsiya, a self-financed State holding company, historically has been the sole distributor and regulator of drugs in Kazakstan. In 1995, Farmatsiya was dissolved. State-owned retail pharmacies continue to receive subsidies from the government for providing certain drugs to the population. In the meantime, many retail pharmacies have been privatized. They are now allowed to make a profit on their sales, as long as they provide certain drugs to the population at low prices. The coexistence of state-owned and private, retail pharmacies creates a confusing regulatory situation for the state, and a confusing consumer market. There appear to be no workable solutions to resolve this issue in the short term. Further regulatory reform is needed at the national and local levels.

Concepts of Health Insurance in post-Soviet Societies

Three sessions dealt with different aspects of health insurance in former Soviet countries.

One of the sessions was chaired by Gary Gaumer, Abt Associates' Program Vice President for Health and frequent advisor on health insurance issues for Zdrav*Reform*. In his opening remarks, he proposed the following framework that encompasses the broad scope of financing reforms referred to as "insurance reforms:"

1. Decoupling health financing from the government budget;
2. Creating an entity (or entities) that employs professional management charged with keeping it (them) solvent by managing the inflows of funds to be used to pay providers for covered health services;
3. Making payments to providers of services and payment policy an instrument to match the breadth of covered services with available funding.

Public or private, voluntary or mandatory, narrow or broad scope of covered services—all can be incorporated into this framework, as can notions of single-payer insurance funds or private insurance.

The two speakers in Gaumer's sub-session addressed widely different aspects of insurance reform. One focused on the lessons of the history of setting up the legal framework for insurance reform, largely aiming to isolate negative lessons learned. The other speaker presented an innovative financing approach and a new modeling method for clarifying financing options.

Dr. Nikolai Melyanchenko, Head of the Health Care Committee in Kemerovo, Russia offered an analysis of the ten years of experience with health reform in this oblast, including the initial health insurance law. The new (1994) law on health protection represents the result of a period of

experimentation and reflection. It incorporates corrections for many of the "lessons learned" during the previous ten years. Among the more important of these lessons are:

- Health protection laws are preferable legal instruments to insurance laws;
- Be specific in the law about the role(s) of government and the private sector;
- Include provisions pertaining to premium/fund collection issues and for the funding of medical education.

Dr. Melyanchenko also stressed the importance of including provisions for assessing the performance of individual insurance funds. Here he supports the requirement of annual assessments of the funds' performances against a set of criteria specified in the new law.

Discussion following this presentation focused on the process of obtaining legislative approval for such a complex law and the administrative burdens implied by the law.

Dr. Alexander Telyukov, Health Finance Specialist based in Zdrav*Reform* Headquarters in Bethesda, summarized his work in Karakol, Kyrgyzstan, where he modeled an approach to a mandatory health insurance fund using a flow-of-funds methodology. He applied the methodology to a financing reform scenario that makes the transition from funding the health sector by general government budget revenues to funding it through a share of value added tax (VAT) revenues and tax incentives to employers to prompt compliance. Under the scenario, VAT rates are gradually increased to generate extra revenues earmarked for payment of health services, and the administrative tax collection process is used to aid implementation and compliance. The simulation analysis showed that the VAT would have to move from 19 to about 23 percent to achieve the equivalent of full, current levels of financing of health providers. The funds flow method allows a fairly transparent view of sources and uses of funds to support these conclusions. A novelty of the proposed approach is the integration of insurance reform and tax policy. While this may capitalize on the existing administrative apparatus, it does entail broader acceptance across government agencies regarding issues of tax policy changes.

The discussion that followed focused on the appropriateness of the VAT as a financing source and peculiarities of local areas where the VAT does not apply to all firms. Also questioned was the appropriateness of payment of taxes by health service providers to support insurance funds.

The session chaired by Dr. James Rice, the Director of Zdrav*Reform*/Russia, included three papers. Dr. Rice introduced the session by enumerating nine problems with the implementation of mandatory health insurance in Russia:

- The Ministry of Health and the Mandatory Health Insurance (MHI) Funds are split over which controls the money for health services;
- The poorly defined mechanism for collecting contributions from enterprises allows many of them to underpay;
- The transactions cost of collecting contributions from those who are self-employed is very high;

- MHI Fund management is problematic;
- The overall economy is weak;
- Expectations for MHI are unrealistically high;
- The population assumes that all health services will remain free of charge;
- The 3.4 percent payroll tax is too low to meet the financing needs of the health services sector;
- The dual funding flows from the government budget and MHI confuses providers.

Alexander Okoneshnikov, Head of the Health Insurance Department at the Ministry of Health in Kazakstan, spoke about the new health insurance law in his country. It was motivated by the underfunding of health services from the traditional source: the government budget. Recently, the sector has received only 40 to 50 percent of the funds requested. The strategy to cope with this situation in Kazakstan is to make some reduction in the size of the provider network, to experiment with user payments for selected services, and to establish a payroll contribution into an MHI Fund. The payroll contribution will be 10 percent of existing social fund contributions, which is expected to provide more revenue than the 3.4 percent payroll tax in Russia. The general government budget will continue to support health service providers, as well.

The MHI system, which will pay providers, will be organized as a single, national fund with branches in oblasts and cities. The MHI system's implementation will follow four stages: design, preparation, transition from the old system, and full operation. Use of per capita financing is to begin under the MHI system in 1997. User co-payments are to be demonstrated in some oblasts.

Dr. Alexeiy Russu, Head of the Department of Medical Services, insurance, and implementation of Reforms in Moldova, spoke about alternatives to the institution of health insurance in Moldova. The difficulties currently faced by Moldova's economy make imposition of a payroll tax impossible at this time. Therefore, a national health program has been developed to take other steps to cope with the scarcity of resources. The program has focused on changing the mentality of both the population and health service delivery personnel. The program aims to reallocate resources to primary health services and to develop a market for services. All forms of ownership are now allowed among providers. Programs have been put in place to influence individual behavior to reduce alcohol abuse, tuberculosis, and HIV/AIDS. Government budget funds are being allocated on a per capita basis. Competition among providers and patient choice are being used as means to increase quality of care. More than 240 doctors have set up private practices. generating around 200,000 visits and about $500,000 in revenues in 1995. A private market for pharmaceuticals has developed, and $15 million in savings has resulted. Development of day surgery has saved 13 percent of costs, and an additional 10 percent reduction in inpatient surgery is expected in 1996. Even though it is not the right time to institute a national payroll-based insurance program, an insurance experiment is being conducted in a pilot area. It expects to receive revenues from the state budget, enterprises, and wage earners on a 50-35-15 percent basis.

Dr. Ainagoul Shayakmetova of the Ministry of Health in Krygyzstan explained the health insurance reforms in her country. She spoke about the experiment being conducted in Issyk-Kul Oblast, which primarily is focusing on reforming the provider payment method. An additional

focus is the development of family group practices. The experience in Issyk-Kul is being systematically evaluated using 88 indicators. With the measures of the indicators the Ministry of Health and Parliament will be able to decide which elements of the experience to use in national policy.

Dr. Rice concluded the session by presenting ideas about how government could promote needed changes in the health system. He proposed increased taxes on tobacco and alcohol earmarked for health service financing. He proposed legislation allowing bond financing for restructuring of providers. He proposed tax credits for the following purposes:

- Out-of-pocket spending on pharmaceuticals
- Out-of-pocket spending on primary care doctors
- Donations to providers
- Enterprises investing in health promotion and safety improvements
- Hazardous material cleanups
- Health needs of special populations
- Doctors' development of general practices.

Dr. Marty Makinen, Deputy Director for Technical Program for Zdrav*Reform* Headquarters in Bethesda, chaired the final session focusing on health insurance. He introduced the session by emphasizing the importance of how payments are made to providers under insurance. He noted that real resource availability is in decline and that the desire to raise additional revenues through a payroll-based insurance system is thwarted in the short term by the weaknesses of overall economies. He stated that in addition to potentially increasing revenues, insurance reforms offer the opportunity to increase the quality of care, responsiveness to consumers, and efficiency in the use of resources. Further, the disappointing to unsatisfactory performance of the Soviet health system on all of these counts would not be improved by more resources alone.

Along with insurance reforms, many areas are experimenting with new ways to allocate funds to providers, or payment reform. These payment reforms are being designed to give providers incentives to provide consistent, high quality care, to be responsive to consumers, and to use resources efficiently. The changes in payment methods can be expected to induce providers to change the way they organize their work to respond to the incentives. This means that an important complement to payment reform is allowing providers the freedom to make changes in organization. Several reform initiatives have been inspired by experiences outside the former Soviet Union; however, these reforms are not a simple replication of outside experience. They involve substantial adaptation and improvement of reforms to better fit local conditions. There are traces of:

- U.S. models of health maintenance organizations (HMOs) in Tula, Shymkent, and Kemerovo
- U.S. integrated service delivery systems in Kemerovo
- The Netherlands' Dekker reforms in Kemerovo
- U.K. fundholding in Samara

- U.S. diagnosis related groups (DRGs) in Dzheskasgan.

Dr. Shel Hulac, Zdrav*Reform* Advisor in South Kazakstan Oblast, Kazakstan, made a presentation about setting up a pilot HMO in Shymkent. The lead provider and holder of financial risk for the HMO will be Phosphorus Hospital. Initially, it will cover the health service needs of the workers employed at the Kabisco factory, a Kazakstani-American joint venture.

Because Shymkent's economy is in deep recession, it is imperative to use available resources as efficiently as possible. Study tours sent five senior health sector leaders to the United States to observe how HMOs are organized and how they perform, how health insurance organizations are managed, and how a private pharmaceutical system operates. One result of the study tours was that the leaders were ready to consider the development of a pilot HMO. A number of onsite activities also helped pave the way for the pilot HMO, including training of the MHI Fund board in strategic planning. a workshop on alternative payment methods. training in management and cost accounting, and a workshop on continuous quality development. All of these activities helped build consensus among the Oblast Health Department, Oblast Administration, City Administration, hospital, and polyclinic about the HMO pilot.

Now, there is a plan in place to make the HMO operational. It will have official legal status by December 31, 1995. Various contracts involved are now under negotiation. The HMO should be operational by April 1, 1996, covering the health needs of about 50,000 people.

Dr. Jamal Tajikenova, Deputy Director of the Health Department in Dzheskasgan Oblast, Kazakstan, described the experience there with pilot implementation of mandatory health insurance in 1995. The program in Dzheskasgan involves financing health services through a combination of general government budget funds, out-of-pocket payments by users, and health insurance contributions. The latter consists of a 5-percent payroll contribution by enterprises. Per capita payments of 1,400 tenge are made to providers for inpatient care and per-visit payments are made for outpatient services. The payment mechanism is expected to motivate a shift in focus to primary care, including tuberculosis control. Restructuring of providers is not being forced, but is expected to come about as a result of facility managers' initiatives.

Facilities are given financial autonomy and development of private service provision is supported. There are 25 general practice groups operating now in Dzheskasgan City. These groups have generated operational savings compared to polyclinics. A system of licensing and accreditation is in place, beginning with provider licensing, which allows contracts to be made with the insurance fund. A commission grants licenses.

Finally, the move to develop insurance has been accompanied by restructuring of the Oblast Health Department (OHD). The OHD has reduced its staff and now concentrates on defining policies and strategies for care. Its analysis department evaluates the impact of initiatives.

Dr. Dmitri Sokol made a presentation on HMO development in Tula, Russia. The development of an HMO was motivated by a recognition that there is much duplication of services and, too often, unneeded inpatient care. Tula health authorities learned about the American HMO model and the incentives it provides to reorganize care. Thus, they applied for Zdrav*Reform* grant support to conduct an HMO demonstration involving Tula City Hospital Number 1.

Through Zdrav*Reform*'s grant, Tula has benefited from assistance and cooperation with the State University of New York at Albany. With Albany's help, a series of issues was defined, including legal status, personnel, and business and implementation planning. A precedent-setting agreement with the City Administration of Tula established a Tula-Albany *not-for-profit* health insurance entity, the first of its kind in Russia. A *not-for-profit* entity was not illegal; it simply was not provided for in Russian law.

A new HMO board of directors, which appoints a chief executive officer, was defined. An incentive-based personnel payment system was devised to increase employee interest in the HMO's overall financial performance. Retraining of personnel and autonomy of management have been found to be key elements of success. After studying the relative efficiency of the hospital departments, creating day beds and centralizing paraclinical (ancillary) services are expected to generate savings.

Economist Natalia Nikolaeva, Deputy to the Chief Doctor of the Oblast Clinical Hospital for Children in Tver, Russia, made a presentation on methods used to estimate costs per case of care. Neither DRGs nor medical economic standards (MESs) are used. Department heads in the hospital are asked to make clinical groupings of cases. Then, the total expected cost is divided by the number of cases to obtain overall average cost per case. However, an adjustment is needed for complexity of cases. Average length of stay (ALOS) is multiplied by average bed-day cost, with that total multiplied by a complexity weight to produce an adjusted value. The complexity adjustment was designed by a group of doctors using statistical data. These calculations were performed using a database including information from 29 facilities.
One example of the calculations is the following. Initially, the calculations performed found an ALOS of 9.6 days for appendicitis, lower than the 10.0 days in MESs. Additional analysis of data showed that an ALOS of 8.8 days should be the target. The fact that savings from application of these methods are used to fund staff bonuses has made staff very interested in applying the methods.

Payment Incentives for Structural Change

Two of the concurrent sessions concentrated on the incentives embodied in the way providers are paid for services. The first of the sessions was chaired by Dr. Makinen. In his introduction to the session, he stated that payment reform is important to getting the most from the health system. He then enumerated several aspects of payment reform.

The first is the origin of payment to providers. It may come from voluntary or mandatory health insurers, from employers through managed care contracts, from consumers directly, as well as through the traditional government budget, or from a combination of all of these sources.

How payment is made impacts provider behavior. Payment made on the basis of the number of filled beds generates filled beds by providers. Per capita financing, case-based financing, and fee-for-service financing embody different incentives, and hence generate different behaviors by providers.

One complement to payment reform is autonomy of management of providers. Without autonomy of management, providers cannot react to incentives embodied in payment methods.

Finally, providers need upgraded accounting, financial management, and information systems to be able to best respond to the incentives in payment methods.

The first paper in the session was presented by Jemma Jafarova, Head Doctor, and Svetlana Bychenko, Chief Economist. City Hospital Number 1, L'viv, Ukraine. They explained how the operation and management of the hospital had changed under new forms of payment and self-governance.

L'viv City Hospital Number 1 has been given the status of a legal entity, so it is not subject to the restrictions of line-items in the allocation of its budget. This has allowed it to change the way it is organized as increased competition has pushed it to change. The hospital is now much more service oriented. Customer service has become the most important consideration. It has better integrated inpatient and outpatient services, cut ALOS, reduced operating costs, and introduced clinical protocols to increase efficiency.

A point system has been set up to reward personnel for performance. The resulting bonuses have led to better performance, including a greater emphasis on prevention and a reorganization of the way care is provided. The decentralization of budgeting to departments has improved cost reporting. Clearly, changing the payment method and granting management autonomy has had a profound effect on L'viv City Hospital Number 1.

Jack Langenbrunner, Zdrav*Reform* Senior Economist, reported on simulations performed to calculate likely cost savings from shifts from inpatient to outpatient care in Kaluga, Russia. Currently, 70 percent of health sector resources are devoted to inpatient care. There is a desire to try to provide personnel with pay incentives for better performance and to increase doctors' total compensation. One way to generate additional funds to use for performance bonuses is to shift care from inpatient to outpatient settings. A computer simulation was performed to get an approximation of the savings that could be expected. A group of expert doctors examined the top 20 ICD-9s for inpatient admissions and found that 35–45 percent could be treated on an outpatient basis: This shift of care would allow for reduction of 2,300 of the 12,300 hospital beds in Kaluga. If all savings from the redundant 2,300 beds were realized, $6.6 million would be gained. However, the savings would be made only if redundant personnel could be released and other

fixed costs reduced. Assuming that only 40 percent of the potential savings can be realized from the hospital bed reduction and accounting for an increase in costs for the greater use of outpatient services, the net savings of the shift are estimated to be $650,000. Greater amounts of resources could be freed up if savings in fixed costs could be increased.

Dr. Igor Samchenko, Advisor in Zdrav*Reform's* Shymkent Office, made a presentation on how new payment mechanisms can improve the effectiveness of health services. Payment mechanisms can be designed to ensure that a minimum package of services is provided and that quality is ensured. Each of various payment mechanisms has advantages and disadvantages, so a mix of mechanisms may be used to minimize the disadvantages. A good mix would be to apply capitation payment for primary care services; government budget support for fixed costs of hospitalization and case-based or global budget financing for operating costs; and fee-for-service payment for elective services. For these payment systems to work as intended, consumers must have a choice of doctor and nurse.

In South Kazakstan Oblast (SKO) experiments are being conducted with methods of payment. Using the principle that money should follow patient choices, an HMO is being developed to create a framework for payment under the coming mandatory health insurance system. Controls are being reduced on how providers use resources to give them the opportunity to respond to payment incentives. Quality assurance mechanisms are being developed, as well. SKO is making the transition to per capita financing.

Dr. Anatoly Shubin, Chief Doctor of the Municipal Self-financing Polyclinic in Odessa, Ukraine, explained his facility's success in generating user payments to support operations. The polyclinic allows patients free choice of specialists, among its staff of high quality and, often, unique specialists in Odessa. Initially, the list of prices for services was authorized by the Ministry of Finance of the Soviet Union. Now, the Municipal Health Department has given polyclinic management the freedom to set its own prices and to decide how it will be structured. This latter freedom has allowed it to open a dental clinic. The revenues from user payments are used to pay staff salaries, with any remainder returned to the state. The polyclinic offers standard services, home care, ambulance services, and has primary care doctors scattered around the city. Utilization has stayed relatively high despite recent difficult economic times. The polyclinic continues to attract high quality specialists on its staff to maintain its reputation with consumers. It also has dismissed unproductive staff to keep quality up and costs low. Veterans and patients referred through social support services are provided care at no charge. The polyclinic earned 7 billions koupons of revenue in 1994, 25 percent of which went to pay professional staff salaries. Although profitability is not a major issue, the polyclinic does face some problems. Among them are heavy taxation of the payroll and some inefficiency, identified with the help of Zdrav*Reform*, in the pharmacy and X-ray departments.

The Zdrav*Reform* Resident Advisor in Odessa, Ukraine, Tom Wittenberg, chaired the second sub-session on payment reform. It was made up of two papers concerning payment reforms in Issyk-Kul Oblast, Kyrgyzstan and Tomsk, Russia.

Dr. Tokon Ismailova described the establishment of a case-based payment system. She gave some detail about how cases are grouped for payment, then described how payment is made to providers on the basis of estimated average cost. Average costs were calculated from information gathered from providers in three districts. This information was used to calculate an index to compare efficiency levels among hospitals. Finally, the speaker noted that the payment system can have the maximum desired impact on efficiency only when it is combined with management autonomy. This would give management the ability to respond to the incentives in the payment method.

Dr. Alexander Telyukov made the second presentation. He added some to the description of the Issyk-Kul payment system, with which he has been involved. Then he turned to Tomsk.

Concerning Issyk-Kul, Dr. Telyukov suggested that together the set of payment reforms, autonomy of management, and implementation of licensing and accreditation would provide the best results.

From his work in Tomsk, Dr. Telyukov demonstrated statistical results that support the need for alternative payment systems. He argued that, at this point, DRGs are the most cost-effective way of paying providers. DRGs could be expanded in complexity in the future. Payments made based on medical-economic standards would require the review of all clinical protocols. This is too demanding and labor intensive. DRGs are simpler, less information intensive, and better for the current situation, Dr. Telyukov suggested.

Dr. Michael Borowitz chaired a plenary session on payment methods. Dr. Teiyuitov elaborated on the management accounting and case-grouping methods developed with hospitals in Tomsk, Russia. Sheila O'Dougherty and Eugene Kutanov of Zdrav*Reform*/Almaty made a presentation, featuring projection of computer spreadsheets, on how the patient classification work was done for the payment method in Issyk-Kul, Kyrgyzstan. Finally, Tatyana Makarova of Zdrav*Reform*/Moscow made a presentation on setting prices for providers integrating the payment over various levels of provider, using such methods as capitation and fundholding.

Decision Methods and Business Skills for Now and the Future

The sessions covering methods for decision making and development of health business skills were the most numerous of the Conference. Five sub-sessions were devoted to these topics.

The four-member Karakol Marketing Group made the first presentation. Their presentation focused on the marketing campaign accompanying the implementation of small group practices in Issyk-Kul Oblast. The campaign aimed to inform the population of 280,000 in the reform area about patient choice among small group practices and the role of family doctors. Focus groups of 10-20 people of various ages were organized to find out what people knew already, what their opinions were, and what they wanted to know about the reformed system. The campaign included all of the following:

- Brochures and information sheets in Kyrgyz and Russian
- House-to-house interviewing and distribution of brochures and information sheets
- Newspaper articles, national and local radio broadcasts, and TV spots and programs
- Bus advertising
- Contests in schools (e.g., essays on "Why I Like my Family Physician," elementary art contests)
- Information dissemination through kiosks at the Karakol main bazaar
- T-shirts and lapel pins
- Children's coloring books
- Information chains from school children to parents to other family members
- Information dissemination to workers at plants.

In the question and answer period. the marketing group explained that the small group practices are made up of an internist, a pediatrician, and an obstetrician/gynecologist plus two to three nurses and a financial manager. The financial manager is important to allow the medical staff to concentrate on medicine, while he or she takes care of financial matters. Each group is to act as a financially independent entity.

The next presentation focused on the efficiency changes made at Odessa Oblast Clinical Hospital. Olga Skayarina, the hospital's Chief Accountant, explained that new methods for paying for services were developed to stimulate productivity. An experiment has begun involving two departments of the hospital. Payment for services in the experiment was calculated in terms of procedures performed, length of stay, and indirect labor costs. Payment for a case is given to the team responsible for care. The early results of the experiment have been:

- Improved quality
- Faster treatment
- Shorter length of stay
- Higher bed occupancy.

To improve the accuracy of the amount paid a step down methodology of calculating costs per case is now being used.

Finally, Dr. Stan Tillinghast, Quality Assurance Director, Zdrav*Reform*/Russia, gave a presentation on ambulatory indicators that have been in use in Siberia.

Charles Krakoff chaired another sub-session on decision making methods. Three papers were presented in the sub-session: one on an information system for mandatory health insurance in South Kazakstan; one simulating the savings from strengthened primary health care in Dniepropetrovsk, Ukraine; and one on a practical solution to the need for financial management tools by small group practices in Issyk-Kul, Kyrgyzstan.

Dr. Nariman Amireev, the former head of the Mandatory Health Insurance (MHI) Fund of South Kazakstan Oblast, described the reporting method designed for providers to use in the MHI system. The method is to allow the MHI Fund to interact with insurance companies, inpatient and outpatient providers, employers, HMOs, and Fund branches. The unified reporting form, which can be used manually or with computers, should allow verification of actions by the various actors in the insurance system and permit analysis and forecasting by the MHI Fund. The method is being implemented at the Phosphorus Hospital in Shymkent.

Dr. Valeria Lehan began by describing the overspecialization of medicine in Ukraine. Only about a third of patients are seen at the primary care level, compared to more than 70 percent elsewhere in the world. Too often, patients refer themselves to specialists. At least a third of diagnoses now treated by specialists could be transferred to primary care. A change in financial incentives is recognized as needed to make the change to greater emphasis on primary care. Three kinds of payment methods are considered: fee-for-service, case-based payment, and capitation.

To examine how each payment method might perform, a mathematical simulation model was constructed that included doctors, the population, and the administration of the system. Simulations were performed of each of the payment methods under different assumptions concerning the percentage of requested funding available—60, 80, and 100 percent. Under 60-percent funding, fee-for-service dominated. Under 80- and 100-percent funding, captiation dominated.

Bakyt Akhmatov and George Purvis presented the third paper, which was on the implementation of a financial management accounting system for small group practices in Issyk-Kul, Kyrgyzstan. As small group practices develop in Issyk-Kul, financial management, which was previously taken care of by the health administration becomes the responsibility of the group. Hence, they need a simple system that produces the information they need for making payments, billing, and decision making.

A search of experience in the West determined that the “peg board” system, used by many groups of one to ten doctors in the United States and elsewhere. is the best fit. It is a manual “one-write” system that nearly is fraud proof. It generates a number of reports: profit and loss, revenues, balance sheet. cash position. accounts payable. and payroll. The “peg board” system has been tested in Issyk-Kul and. as a result, has been revised in several iterations to meet local needs.

Linda Moll, Training Specialist, Zdrav*Reform*/Bethesda, chaired the third sub-session on decision making and business skills focused on training.

Dr. Kalkaman Aiapov, Director at the Almaty Medical College, gave the first presentation. He spoke about reforms in nursing education. Three new laws support nursing training in Kazakstan: a law on the professionalism of nurses, a law on payment; and a law on the integrity of the training process and science. To counter the trend of fewer people applying for nursing training, there are moves to improve job satisfaction, increase continuity of training, and decentralize and democratize training. There are four steps to nurse training, with nurses’ pay depending on the

level of training attained. The steps are: nursing assistant (one year of training); clinical specialty training (third year); management and administrative skills training (fourth year); and postgraduate training.

Dr. Yaroslav Basylevich, Head of the Health Administration Department of L'viv Medical University, explained the development of management training. He noted that western Ukraine has a long history of health insurance, dating to the 19th century. The management training program is trying to gain exposure to world experience. Through Zdrav*Reform* assistance and the help of others, it has trained faulty and students in payment methods, health delivery systems, case management, medical-economic standards, contracting, pricing and costing, cost accounting, and licensing and accreditation. In addition to the technical knowledge gained, the Health Administration Department is pursuing practical knowledge by conducting case studies in facilities and surveys of providers. This academic year the University will award its first master's degrees in health management.

Lonna Milburn made the third presentation of the sub-session. She described making the conversion to family medicine, involving nurses, doctors, and patients, citing the example of Altai Krai. The family medicine approach provides continuity of care. Family doctors act as gatekeepers to referral services of specialists,. As a result, they require training in management, planning, relations with employees, responding to competition, quality, costing, and health insurance. Nurses often make up the largest group of care providers in family medicine. Patients are expected to take charge of much of their own health by curbing smoking, ensuring that children are immunized, and working to prevent illness.

Dr. Ivan Solonenko, the Head of the School of Health Administration in Kiev, Ukraine, made the next presentation. The School was founded three years ago to provide a one year training program to doctors in management and administration. The program includes training in epidemiology, policy, economics, information systems, and English language. The School is actively training its faculty by having them learn from outside faculty from the United States (through Zdrav*Reform*), Canada, and Western Europe, when the latter come to teach short courses. One problem faced by the School is a shortage of training materials in Ukrainian.

Tatyana Fomina, Chief Economist of Tomsk City Hospital Number 3, was the final speaker of the sub-session. She spoke about how the training in management accounting provided by Zdrav*Reform's* Alexander Telyukov had transformed the thinking and understanding of City Hospital Number 3's management. Before the training, the hospital was at a loss to understand how to implement market-oriented management accounting. The implementation of management accounting has complemented other reforms at the hospital, including incentive-based pay to employees, development of family practice groups, and additional training of nurses and managers.

Sheila O'Dougherty of the Zdrav*Reform* office in Almaty chaired a sub-session focused on the application of computers and information systems in health reforms. The three presentations in the sub-session covered work in Kyrgyzstan, Ukraine, and Russia. Some of the issues that cut across the three experiences are:

- Top-down versus decentralized information systems
- Control of doctors through information systems, particularly through the use of medical-economic standards
- Constraints on the use of computer systems.

Zhenya Samushkin and Andre Timoshkin of Zdrav*Reform*/Almaty presented on the information system developed to support the reforms being implemented in Issyk-Kul, Kyrgyzstan. The information system is involved in the following elements:

- Population enrollment with family group practices
- Calculation of capitation rates
- Processing of clinical data from hospitals
- Calculations of weights and rates
- Accounting and banking transactions for hospital payment
- Health statistics for quality assurance.

A statistics unit enters data on population enrollment, family group practices' referrals. and hospital admissions, discharges, and billings. Revenue is tracked from general budget allocations and employer contributions under mandatory insurance. Payments are tracked from invoices from providers to their final payment by the MHI Fund.

Dr. Yuri Prokopchuk of the Dniepropetrovsk Academy of Medicine in Ukraine made the second presentation. He described a set of uses of computer information systems:

- Information needs within provider organizations and to satisfy external demands
- Registration of providers
- Quality control
- Hospital billing
- Physician profiles
- Intellectual support to physicians (manuals)
- Medical information networks.

Management information systems are relevant for the following:

- Matching results to treatments
- Quality assurance
- Physician profiles
- Investigations

- Morbidity analysis
- Study of patient flows
- Study of costs.

Dr. Prokopchuk discussed a set-up whereby doctors could work directly with computers, entering diagnosis and treatment information about patients seen. This would facilitate paying doctors and controlling their performance.

Greater use of computer information systems in providers is hindered by lack of software manuals, training, demonstration projects, and skilled personnel. The latter is the result of a brain drain caused by the low salaries paid in the health sector. One solution proposed for some of these problems is the creation of a regional training center.

Dr. Roman Zelkovich, Director of the Center for Medical Information in Kemerovo, presented the experience of information system support to the health insurance system in Kemerovo. He described the databases that have been set up, the assessment of costs that has been performed for the territorial MHI Fund, and the calculation of payments for medical services. The latter Dr. Zelkovich characterized as very complicated. Further, the experience in Kemerovo is that hospitals have not been particularly responsive to payment methods. The issues that are on the Kemerovo agenda are: analysis of why there have been successes and failures, how to implement a system including insurance companies and a territorial MHI Fund, how to determine who is insured and who is not, and protection of the rights of the insured.

Dr. Stan Tillinghast, Quality Assurance Director of the Zdrav*Reform*/Russia, chaired a sub-session in which the speakers addressed experiences in developing systems to ensure quality of care in Russia, Ukraine, and Kazakstan (at both the oblast and national levels). Each of the speakers approached the quality issue from a different perspective, by introducing economic incentives to health facilities to improve quality, developing licensing and accreditation systems for hospitals and other medical facilities, and introducing formal legislation.

Dr. Alexander Danilenko of Zdrav*Reform*/Almaty described the development of a system of facility licensing and accreditation to increase and control quality of services under decentralization, privatization, and insurance. Dr. Danilenko said that licensing usually is a state function, and should be the prerogative of the Ministry of Health. Accreditation should be a function conducted by an independent agency. A licensing and accreditation system developed by Zdrav*Reform* includes six parameters for licensing and 19 accreditation standards. The accreditation standards are based on a scale of one to three, with 80 percent as a minimum passing level. Further licensing and accreditation standards are being considered to include economic and equity aspects of the health care system. Any institution falling below 70 percent would be closed and those falling between 70 and 80 percent would have a one-year period in which to improve. These criteria fit within the existing Kazakstan licensing legislation. A more formal accreditation system needs to be developed.

Dr. Alla Stepanenko of the National Institute of Health in Kiev, Ukraine spoke next on quality assurance in her country. She stated that the state's purpose in developing a licensing and accreditation system is to ensure quality care to the population during a period of increased decentralization of the health sector from national government control. Ukraine has passed enabling legislation. but enumeration of specific standards has not yet been done.

Dr. Galina Tsarik, Director of the Institute of Health and Social Problems in Kemerovo, Russia, spoke about the use of medical-economic standards for assuring quality. Beginning in 1985, Kemerovo was one of the first areas to restructure the health care sector to reflect a smaller role for the state. To this end Medical Economic Standards, linking financial incentives and quality standards to health procedures, were instituted in Kemerovo health facilities. Under MES, if a physician is found to have deviated from the outlined procedures for a given illness, his or her pay is reduced, depending on the severity of the deviation. In this way, physicians have an incentive to give quality care.

Igor S. Zakcharov, President of the Mandatory Health Insurance Fund in Dzheskasgan Oblast, Kazakstan, described the efforts the MHI fund to institute a system to assure quality care while controlling costs. The methods used concentrate on monetary punitive measures for failing to meet clinical standards (e.g., number of bed days for a specific diagnosis).

The results from the first four months of implementation of the program are promising, though they must be considered only preliminary. In the first two months of implementation, there was no discernible improvement in quality. In the following two months, however, there was a 20 percent improvement. Average length of stay dropped during this time.

Restructuring Health Systems

Three sub-sessions covered various elements of restructuring of health services in former Soviet countries.

Dr. Nancy Pielemeier, Zdrav*Reform* Director, chaired the first sub-session in this area. The first paper in the sub-session described the demonstration of health system reforms in Issyk-Kul Oblast, Kyrgyzstan. The speaker, Dr. Damira Salieva, described the development of new financing sources, provider payment methods, small group practices, and rationalization of services. Mandatory health insurance contributions by enterprises and user payments are to supplement traditional state budget financing. Per capita allocation of funds with money following patients is to replace bed occupancy-based spending. USAID support for renovating and equipping facilities has helped to establish small group practices involving an internist, pediatrician, obstetrician/gynecologist, nurses, and a manager. Some hospitals have been consolidated and others closed as the new emphasis on primary care and payment method reduces the use of hospital beds.

Dr. G.K. Nokina of the Ministry of Health of Kazakstan, spoke next about the development of standards for a national licensing system. The system is akin to medical economic standards, with both quality and financial indicators. In the discussion that followed, Dr. Maksut Kulzbanov, Deputy Minister of Health in Kazakstan, added that the standards are to be used as a part of a licensing law for providers. Dr. Nikolai Melyanchenko, Director of the Department of Health in Kemerovo, Russia, noted that medical economic standards are used to measure volume of care, in addition to quality and costs.

The third presentation of the sub-session, by Dr. Albert Trauter, Head of the Kemerovo, Russia, Mandatory Health Insurance Fund, addressed the implementation of the 1991 Russian Health Insurance Law. There are now Funds in all 89 territories of Russia and 296 health insurance entities. The most successful Funds are in Kemerovo, Novosibirsk, Altai Krai, Tomsk, Irkutsk, and Krasnoyarsk. Kemerovo has 15 insurance entities, including two state-owned and eight private insurance companies. The Funds gain revenue from state budget allocations, employer mandatory payroll contributions, and, theoretically, from interest earned from the funds held on deposit. The functions of an MHI Fund are the following:

- Monthly indexation of inflows and expected outflows of funds to pay for services
- Coverage of the health services needs of 100 percent of the population
- "Control" of insurance companies, including making annual agreements and quality control using medical-economic standards.

A key aspect of Kemerovo's success is the close relationship among all actors, including the Department of Health, MHI Fund, the Board on Social Insurance, and the Committee on Licensing and Accreditation.

The discussion that followed focused mainly on what kinds of problems the Kemerovo system has had. One problem cited by Dr. Trauter is lack of access to social insurance funds by the MHI Fund. A caution from many of those involved with Kemerovo is that the system that has evolved there over the last ten years is complex and should not necessarily be emulated in all of its aspects. Certain elements may be successfully adapted elsewhere, however.

Four presentations, two each from Ukraine and Kazakstan, were featured in the sub-session chaired by John Stevens and Dr. Borys Uspensky of Zdrav*Reform*'s office in L'viv, Ukraine. They cited the following themes in introducing the presentations:

- There is a growing shift from inpatient to outpatient care;
- Anticipation of per capita financing is prompting an awareness of costs;
- Restructuring often begins at the facility or rayon level;
- Incentive-based pay is being used to increase productivity;
- An important effect of restructuring is on quality of care.

The first speaker, Dr. Murat Mumenov, Head of the Health Department of South Kazakstan Oblast, explained how the SKO health system is being restructured to adapt to the economic crisis precipitated by the transition to the market. One effect of the crisis has been the need to close 2,500 hospital beds in the last three years. The Health Department has the following restructuring plans:

- Modify district hospitals to add outpatient clinics in areas with high proportions of females and children in their populations;
- Make seven health facilities self-supporting;
- Have 30-40 bed hospitals serve rayons;
- Implement a licensing system (planned for December 1995);
- Introduce family medicine and salary incentives for rural doctors;
- Stress preventive services;
- Introduce mobile health services in one rayon;
- Combine maternity and pediatric service to provide continuity of care to mothers and their children;
- Establish new training facilities for doctors and nurses in Shymkent.

Dr. Akim Litvak, Secretary of the Reform Coordination Council in Odessa, Ukraine, spoke about the planned restructuring there. He emphasized the necessity for continued state budget support of the health system, including support for drugs. He emphasized the importance of preserving what is good about the system while undertaking restructuring. Consideration should be given to ensuring a minimum package of benefits, including some inpatient and outpatient care and dentistry. All tertiary care should be covered, along with emergency primary care and specialist services.

Dr. Sergey Krivtsov, Head Doctor of Shymkent Regional Eye Hospital, Kazakstan, made a presentation focusing on the establishment of a private-pay wing in the hospital. The private wing was set up as a joint stock company. It includes a small. high-technology diagnostic unit. televisions in patient rooms, and a private pharmacy. Employees of the wing receive 50 percent of their wages from the state budget and 50 percent from private payments. Their wages are three times those of other similar employees, giving them the incentive to be more productive. The revenue generated by the private wing has allowed the hospital to make additional improvements, including the purchase of a bus to transport its workers.

Dr. Krivtsov was asked how prices are established for the services in the private wing. He replied that charges are based on costs. He also answered a question about how the wages of those working in the private wing are established by saying that they are set according to the laws of Kazakstan, with a 50 percent bonus paid from the wing's revenues.

The final speaker of the sub-session was Larisa Matsalyshchenko, Deputy for Economics at Maternity Hospital Number 1 in Odessa, Ukraine. Hospital Number 1 has suffered from many negative trends lately. Bed occupancy has declined with a sharp drop in the birth rate; cancers and complications in maternity have increased; the physical condition of the facility has

deteriorated; and funding has been reduced progressively from 100 percent of request in 1993 to 64 and 27 percent of request in 1994 and 1995. In this context, the hospital has looked for ways to economize.

One successful effort has been the creation of an alternative care unit. This unit offers 30 day beds to allow women to have access to good quality care, but also to stay at home. A key service it offers is control of infectious diseases during pregnancies. About 25 percent of pregnant patients are admitted to the day beds. The day-bed unit allows savings of food, laundry, and selected drugs' costs, plus some doctor and nurse time. The results of this set up are the following:

- Increase of 12.3 percent in maternity patients
- Increase of 14 percent in gynecology patients
- Decrease of 2.9 percent in infections
- Reduction in average length of stay from 11 to 8 days.

Mr. Stevens and Dr. Uspensky summarized the presentations in the following points:

- The main driver of the reforms is consumer choice;
- Provider response is the essence of restructuring;
- The quality of services offered will determine the acceptability of user charges;
- Self-financing strengthens self-governance, which in turn perpetuates quality;
- There is a commonality of goals of restructuring at the oblast, rayon, facility, and subfacility levels.

Dr. Jack Langenbrunner chaired the last sub-session in this category, which discussed experience, evidence to date, lessons and the remaining challenges faced by health providers and institutions throughout the NIS as they test ways to restructure the health system. Each of the countries represented at the session (Kazakstan, Ukraine and Uzbekistan) have examined and initiated demonstrations of various financing schemes to improve health care.

The sub-session focused on alternative approaches related to public-private mix in the organization and delivery of services. Dr. Langenbrunner stated that, clearly, a number of private and non-governmental initiatives have emerged across the NIS. As in other countries, such as those in Western Europe and in the United States, the issue of ownership has been controversial. The relationship between ownership of the means of health services production and efficiency and equity and health outcomes is not always clear. Likewise, there is no consensus on the preferred approach to ownership in these or other countries.

The first presenter, Dr. Rosa Abzalova, Director of the Private Cardiology Center in Dzheskasgan, Kazakstan, examined long-term costs of certain diseases contributing to mortality and morbidity in Dzheskasgan oblast. Her study results confirmed anecdotal data that cardiological diseases are the largest contributors to mortality in the NIS, and absorb the largest percentage of the health care funds. Traumas, poisonings, and oncologic diseases are the most significant contributors to

cost of care after cardiovascular diseases. The study also found that one cost-effective approach to reducing the cost of cardiovascular diseases is to increase the level of preventive care and primary care services at the early stages of the disease. Health education and lifestyle changes were discussed as future alternatives to specialized care.

Dr. Minjasar Janbaev, Chief Physician, Dzheskasgan City Association, was the lead presenter of a paper on Dzheskasgan's experience in introducing private health care system, including a payment system, through the Mandatory Health Insurance Fund of Kazakstan. Dr. Janbaev reported that private clinics are able to work within the MHI Fund with payment according to a confirmed tariff for each medical service provided. This private, "fee-for-service" approach is a prototype for other private practices in the oblast. There are private clinics in the areas of pediatrics, internal medicine, and dentistry. These demonstration models have encouraged several behavior changes: greater interest in patient satisfaction, more services for the care of the patient, and increased productivity on the part of the provider. Future analysis should focus on changes in volume and spending by the Fund and the relationship of these changes to other patterns of care (e.g., changes in referral patterns to specialists and hospitals).

Dr. Kamil Akrimov, Head Physician, Tashkent State Medical Institute No. 2, presented a paper by Dr. Khamid Karimov, the Institute's Director, on the organization of and new approaches to hospital treatment in Uzbekistan, including efforts to improve the quality of care associated with new forms of treatment. One approach is the use of comprehensive testing before and rehabilitation care after hospitalization. Often termed "pre-admission testing" and "post-acute management of care" in the West, this approach has led to an ALOS reduction of two days, with associated estimated, two-year savings of $105,000.

Dr. Akrimov reported that the Uzbek health system also has begun to place greater emphasis on outpatient care, both through the use of day-care centers and in provision of training to physicians in the use of outpatient treatment. Overall, substituting outpatient care for inpatient care has been found to be one-fourth as expensive.

Alexander Khapin and Larisa Matsalyshchenko, Head Doctor and Deputy for Economy, Maternity Hospitals Amalgamation No. 1, Odessa, Ukraine, discussed the results of restructuring at the Obstetric Services Facility in Odessa, Ukraine.

The amount of funds from government budgets to the facility has dropped over 50 percent between 1994 and 1995. These funds could cover only the everyday costs of running the facility, including 25 percent towards the purchase of pharmaceuticals.

To increase revenues, the facility introduced out-of-pocket payments. This cost-sharing initiative has increased revenues overall by 20 percent, and allowed the use of new funds for increasing doctors' salaries by 10 percent. The facility also has begun negotiations for partnerships with large, private companies from outside Ukraine. Funds generated through these contracts would be used for model delivery programs and to purchase much-needed equipment and supplies.

The final presentation in this sub-session was made by Dr. Ormenbek Zhouzhanov, Director of the Research Center of Medical and Economic Problems, Ministry of Health, Kazakstan. Dr. Zhouzhanov's presentation examined the relationship between national financing and the allocation of funds across oblasts, and the resulting impact on the level of medical care. His study showed that real expenditures on health care have dropped 66 percent from 1990 to 1994, once adjusted for inflation. It was not clear whether the figures were adjusted for inflation using a health care price index or a general inflation index.

There was some discussion of changes in percentage of funds going to various parts of the delivery system. For example, the amounts spent on utilities is increasing as a percentage of the total funds available. However, it is not clear whether the provider community has utilized remaining funds in a way optimal for maintaining health outcomes. For example, the reduction in the number of beds has only has been approximately 12 percent and the reduction in physicians about 10 percent. Coupled with figures on percentage of funds going to utilities, it is suggestive of a health sector that has not adjusted adequately away from its outdated cost structure, and that hospitals, beds and other fixed costs are draining remaining funds away from patients. This deprives such things as new equipment and pharmaceuticals of resources.

There was also a discussion of funding levels among oblasts in Kazakstan. Funding levels vary significantly, and allocations are not always population-based. There was a proposal to develop a population-based approach.With input from Dr. Tatyana Makarova Zdrav*Reform*/Moscow, a discussion ensued about the need to adjust the analyses and allocation formulas for certain factors such as age and sex.

Recommendations also called for further analysis in each oblast to get a more accurate representation of the flow of funds across settings (inpatient versus outpatient).

Experiments in Primary Health Care

Dr. Michael Borowitz, Director of the Zdrav*Reform* Regional Office for Central Asia, chaired the single sub-session devoted to experiments in primary health care. He led off the sub-session by noting growing concerns about the high level of referrals in former Soviet countries and a decreasing number of primary care providers. Dr. Borowitz noted that primary care often is referred to as general practice or family practice.

Nuripa Mulkanova and Dean Millslagle of the Zdrav*Reform* office in Issyk-Kul, Kyrgyzstan, made a presentation on the reorganization of primary care in that area.

The major objective of reorganizing the health system in Issyk-Kul Oblast is to shift from expensive hospital care to more cost-effective primary care. Family group practices, consisting of a pediatrician, internist, gynecologist, were formed independent of polyclinics or hospitals. Family practice physicians are enrolled in a training program, designed to teach them to deal with a wide range of managerial, financial, and administrative concerns. Patients are free to enroll in the family group practice of their choice, as their first point of contact in the health care system.

Additional equipment and pharmaceuticals are needed at the family group practices to make them more independent, and to allow them to decrease referrals to polyclinics and hospitals.

Peter Petrov, Assistant Director of the Research Center on Medical and Economic Problems of Health Care in Almaty, Kazakstan, spoke about the problems for health care in rural areas. The results of a study conducted in several Kazakstani oblasts showed that access to primary care in rural areas is worsening during the transition to a market economy. The main deterrent for patients to use primary care is the increasing cost of transportation to and from facilities. Recommended solutions include using a per capita financing scheme in rural areas, increasing the density of the network of general practitioners, and improving continuity of care.

Dr. Yevhen Polataiko, Chief Doctor at City Polyclinic Number 2 in L'viv, Ukraine, made a presentation about the experiment with family medicine practitioners at his polyclinic. The experiment was conducted to see how families would be affected by using a primary care practitioner for 80 to 90 percent of care under a national medical insurance system. A result of the experiment is that knowledge about the interrelations of the family members and the effect of the home environment on health status was found to be instrumental to effective diagnosis and treatment. Therefore, it was concluded that family practice is an efficient and effective way to diagnose, treat, and prevent disease. One result of this study is that family medicine has become recognized as a medical specialty by the Ukraine Ministry of Health. Further, a family practitioner is expected to be an accepted health provider under a national health insurance system in Ukraine.

Dr. Victor Veres, Head of the Health Administration and Chief Doctor of the Rayon Central Hospital in Zhovkva, Ukraine, spoke about rural health services reform in his area. Increasing financial pressures pushed Zhovkva Rayon to reduce the number of hospital beds from 920 to 725 over two years. A specialty hospital also was closed. These moves were made to make the system more efficient while maintaining quality of care. The decisions about which beds and facilities to close were made with the assistance of Zdrav*Reform* management and financing expertise.Dr. Veres suggested that the lessons learned in Zhovkva will be useful when facing similar problems in other areas and hospitals in Ukraine.

CONCLUSIONS

The presentations at the conference and the discussions that followed testify to the volume of health reform work being conducted across the countries of the former Soviet Union. At all levels of the health systems, national, territorial, rayon, facility, and training institution, market-oriented solutions are being devised, tested, evaluated, and revised. These solutions address the problem of restructuring of the health sector to attain financial sustainability, quality care, equitable access, and efficient use of resources. Substantial learning and cross-fertilization took place at the conference. Different sites are taking different approaches to similar problems, and some sites are more advanced than others in using similar methods. Those working on like approaches gave each other greater confidence to continue to move ahead, knowing that they are not alone. New professional acquaintances were made across countries in both the Conference's formal and

informal sessions. An informal association of health reform professionals began to be established. an element of civil society previously unknown to nearly all participants. The momentum of market-oriented health reform has begun to build. The Conference gave it an additional push forward.

Annex A

Список участников конференции

Abt Associates Inc.

Д-р М.МАКИНЕН	Технический Директор. Программа ЗдравРеформ/АБТ Ассоуэйтс. США. тел.: 301-913-0500. факс: 301-913-0562
Dr. M.MAKINEN	Tecnical Director. ZdravReform Program/Abt Associates Inc., U.S., 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562
Д-р Н.ПИЕЛЕМЕЙЕР	Директор. Программа ЗдравРеформ/АБТ Ассоуэйтс. США. тел.: 301-913-0500. факс: 301-913-0562
Dr. N.PIELEMEIER	Director, ZdravReform Program/Abt Associates Inc., U.S., 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562
Д-р А.ТЕЛЮКОВ	Программа ЗдравРеформ/АБТ Ассоуэйтс. США. тел.: 301-913-0500. факс: 301-913-0562
Dr. A.TELYUKOV	ZdravReform Program/Abt Associates Inc., U.S., 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562
Г-жа К.РОБЕРТС	Программа ЗдравРеформ/АБТ Ассоуэйтс. США. тел.: 301-913-0500. факс: 301-913-0562
Ms. C.ROBERTS	ZdravReform Program/Abt Associates Inc., U.S., 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562
Г-жа Б.БЕРДЖЕСС	Программа ЗдравРеформ/АБТ Ассоуэйтс. США. тел.: 301-913-0500. факс: 301-913-0562
Ms. B.BURGESS	ZdravReform Program/Abt Associates Inc., U.S., 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562
Д-р Г.ГАУМЕР	Вице Президент. Программа ЗдравРеформ/АБТ Ассоуэйтс. США. тел.: 301-913-0500. факс: 301-913-0562
Dr. G.GAUMER	Vice President, ZdravReform Program/Abt Associates Inc., U.S., 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562

Central Asia

Г-н А.КАРАКУЛОВ	Консультант, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Mr. A.KARAKOULOV	Consultant, ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-жа С.АСАНХОДЖАЕВА	Координатор по маркетингу, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, Каракол, Касымова 89-5, тел.: (31922)2-42-34
Ms. S.ASANHODZHAEVA	Marketing Coordinator, ZdravReform Program/Abt Associates Inc., Central Asia, Karacol, Kasim 89-5, tel.: (31922)2-42-34
Г-н А.ИБРАГИМОВ	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия
Mr. A.IBRAGIMOV	ZdravReform Program/Abt Associates Inc., Abt Associates Inc.
Г-н Б.АКМАТОВ	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия
Mr. B.AKMATOV	ZdravReform Program/Abt Associates Inc., Central Asia
Д-р Т.НУНГОЖИН	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия
Dr. T.NUNGOZHIN	ZdravReform Program/Abt Associates Inc., Abt Associates Inc.
Г-н К.АБДРАХМАНОВ	Финансист, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, Каракол, 1 микрорайон, 90-6, тел.: (31922)2-82-42
Mr. K.ABDYRUHMANOV	Finance specialist, ZdravReform Program/Abt Associates Inc., Central Asia, Karacol, Microrayon 1, 90-6, tel.: (31922)2-82-42
Д-р И.САМЧЕНКО	Помощник Администратора по Экономике, БСМП Госпиталь, Казахстан, АБТ Ассоушиэйтс, 480042, Шымкент, Желтоксан 20А, тел.: (3252)41-07-32, факс: (3252)50-61-83
Dr. I.SAMCHENKO	Deputy Administration for Economics, BSMP Hospital, Kazakhstan, Abt Associates Inc.480042, Shymkent, Zheltoksan St.20A, tel.: (3252)41-07-32, fax: (3252)50-61-83
Г-жа Д.НУГМАНОВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Ms. D.NUGMANOVA	ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-жа Л.ГИЛЕВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Ms. L.GYLEVA	ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-н А.ТИМОШКИН	Специалист по информационным системам, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-
Mr. A.TIMOSHKIN	MIS specialist, ZdravReform Program/Abt Associates Inc., Abt Associates Inc., 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-жа К.РАХИМОВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Ms. K.RAHIMOVA	ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70

Г-н Е.САМЫШКИН	Специалист по информационным системам, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-
Mr. E.SAMOUSHKIN	MIS specialist, ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Д-р Н.МУКАНОВА	Координатор офиса, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, Каракол, 1 микрорайон, 90-6, тел.: (31922)2-82-42
Ms. N.MUKANOVA	Office coordinator, ZdravReform Program/Abt Associates Inc., Central Asia, Karacol, Microrayon 1, 90-6, tel.: (31922)2-82-42
Д-р А.ДАНИЛЕНКО	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Dr. A.DANILENKO	ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-жа Ш.О'ДОГЕРТИ	Специалист по информационным системам, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-
Ms.S.O'DOUGHERTY	MIS specialist, ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-н Е.КУТАНОВ	Специалист по информационным системам, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-
Mr. E.KOUTANOV	MIS specialist, ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-жа Б.КОУПЛЭНД	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Ms. B.COPELAND	ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-жа Л.МЫГЛИНА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480042, Шымкент, Желтоксан 20А, тел.: (3252)41-07-32, факс: (3252)50-61-83
Ms. L.MIGLINA	ZdravReform Program/Abt Associates Inc., Central Asia, 480042, Shymkent, Zheltoksan St.20A, tel.: (3252)41-07-32, fax: (3252)50-61-83
Д-р Т.ИСМАИЛОВА	Экономист по вопросам здравоохранения, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, Каракол, Иссыкульская 78, тел.: (31922)2-82-42
Dr. T.ISMAILOVA	Health economics specialist, ZdravReform Program/Abt Associates Inc., Central Asia, Karakol, Issy-kul Str. 78, tel.: (31922)2-82-42
Г-н Ч.КРАКОВ	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Mr. C.KRAKOFF	ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Д-р М.БОРОВИЦ	Директор регионального офиса, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Dr. M.BOROWITZ	Regional Director, ZdravReform Program/Abt Associates Inc., Central Asia, 480064, Almaty, 60 Zhibek Zholy , 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Д-р Н.АЛМАГАМБЕТОВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия
Dr. N.ALMAGAMBETOVA	ZdravReform Program/Abt Associates Inc., Abt Associates Inc.
Г-н М.КАИРГЕЛЬДИН	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия
Mr. M.KAYRGELDIN	ZdravReform Program/Abt Associates Inc., Central Asia

Г-жа М.ПОЛТОРАКИНА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия
Ms. M.POLTORAKINA	ZdravReform Program/Abt Associates Inc., Central Asia
Г-н Ш.ХЬЮЛАК	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480042, Шымкент, Желтоксан 20А, тел.: (3252)41-07-32, факс: (3252)50-61-833
Mr. S.HULAC	ZdravReform Program/Abt Associates Inc., Central Asia, 480042, Shymkent, Zheltoksan St.20A, tel.: (3252)41-07-32, fax: (3252)50-61-833
Г-н Б.АХМАТОВ	Специалист по маркетингу, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, Каракол, Джетизхола 22-9, тел.: (31922)2-42-34
Mr. B.AKHMATOV	Marketing Specialist, ZdravReform Program/Abt Associates Inc., Central Asia, Karakol, Djetizzhola 22-9, tel.: (31922)2-42-34
Г-жа Р.КЕЙН	Программа ЗдравРеформ/Джон Сноу Интернешионал, Средняя Азия, Шымкент
Ms.R.KANE	ZdravReform Program/John Snow International, Central Asia, Shymkent
Г-жа О.ГИЛЕВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Средняя Азия, 480064, Алматы, 60 Жибек Жолы , 7, тел.: (3272)33-56-87, факс: (3272)33-56-70
Ms. O.GYLEVA	ZdravReform Program/Abt Associates Inc., Abt Associates Inc., 480064, Almaty, 60 Zhibek Zholy 7, tel.: (3272)33-56-87, fax: (3272)33-56-70
Г-н Р.СЛАСКИ	Программа ЗдравРеформ/Е.Петрич и Ассоусиэйтес Инк., Средняя Азия
Mr.R.SLASKI	ZdravReform Program/E.Petrich and Associates Inc., Central Asia
Г-н Д.МИЛЛСЛЭЙГЛ	Региональный офис-менеджер, Программа ЗдравРеформ/Девелопмент Ассоусиэйтес Инк., Средняя Азия, Каракол, Интернациональная 3, тел.: (31922)2-82-34
Mr. D.MILLSLAGLE	Regional office manager, ZdravReform Program/Development Associates Inc., Central Asia, Karakol 3 Internatsionalnogo, tel.: (31922)2-82-34

International organizations

Г-н Д.БЕНЕДЕТТИ	Международная организация-AED/NET
Mr. D.BENEDETTI	AED/NET, International organizations
Г-жа Ж.КАРАГУЛОВА	Международная организация-WHO
Ms. Z.KARAGULOVA	WHO, International organizations
Г-жа Л.МОЛЛ	Специалист по обучению, Программа ЗдравРеформ/Девелопмент Ассоусиэйтес, США, тел.: 301-913-0500, факс: 301-913-0562
Ms. L.MOLL	Training Specialist, ZdravReform Program/Development Associates Inc., International organizations, 4800 Montgomery Lane Suite 600, Bethesda MD 20814-5341, tel.: 301-913-0500, fax: 301-913-0562
Г-жа А.ДЖОУНС	Посол, США
Ms. A.JONES	Ambassador, USA, International organizations
Г-н ДЖ.РИТТМАНН	Советник, Всемирный Банк
Mr. J.RITTMANN	Advisor, World Bank, International organizations
Г-н ШАФРАНСКИЙ	Международная организация-EPT
Mr. SHAFRANSKY	EPT, International organizations
Д-р Д.ПУРВИС	Консультант, Программа ЗдравРеформ
Dr. G.PURVIS	Consultant, ZdravReform Program, International organizations
Г-н Д.РАШМАН	Международная организация-SOMA RC
Mr. D.RUSCHMAN	SOMA RC, International organizations
Г-н Л.ВОЛКАШ	
Mr. L.VOLKASH	Mercy Corps, International organizations
Г-н С.БАТТЭРИ	Международная организация-UNIC EF
Mr. S.BATTARI	UNIC EF, International organizations
Г-н БЕРТИС	Международная организация-AIHA
Mr. BURTIS	AIHA, International organizations

Г-жа Д.НУГМАНОВА	Международная организация-AIHA
Ms. J.NUGMANOVA	AIHA, International organizations
Д-р М.КУЖУКЕЕВ	Специалист по управлению проектом, Международная организация-USAID
Dr. M.KUZHUKEEV	Head project Spesialist, USAID, International organizations
Г-жа П.БАКЛС	Международная организация-USAID
Ms. P.BUCKLES	USAID, International organizations
Г-жа М.ШМИДТ	Международная организация-USAID
Ms. M.SCHMIDT	USAID, International organizations
Г-н К.БАК	Международная организация-USAID
Mr. C.BUCK	USAID, International organizations
Г-жа Д.АДИЛОВА	Международная организация-AED/NET, тел.: (3272)63-73-67, факс: (3275)81-15-37
Ms. D.ADILOVA	AED/NET, International organizations, tel.: (3272)63-73-67, fax: (3275)81-15-37

Kazakhstan

Г-Жа Т.СИРБИЛАДЗЕ	Казахстан, Шымкент
Ms. T.SIRBILADZE	Kazakhstan, Shymkent
Д-р Л.ТУРИСБЕКОВА	Директор, Медицинский стандарт, Казахстан, Шымкент
Dr. L.TURISBEKOVA	Director, Medical Standard, Kazakhstan, Shymkent
Г-жа Г.ШИМ	Заместитель Начальника, Экономического Управления, Казахстан, Шымкент
Ms. G.SHIM	Deputy Head, Economic Department, Kazakhstan, Shymkent
Г-жа Б.ТУМЕНОВА	Заместитель начальника по лечебной работе, Областное Управление здравоохранения, Казахстан, Семипалатинск, тел.: 62-26-17
Ms. B.TUMENOVA	Deputy Head, Oblast Health Department, Kazakhstan, Semipalatinsk, tel.: 62-26-17
Г-н И.АСКАРОВ	Начальник областного финансового Управления здравоохранения, Областная Администрация, Казахстан, Шымкент, Туркестанская 91, тел.: 3-37-54
Mr. I.ASKAROV	Head of Oblast Finace Department, Oblast Administration, Kazakhstan, Shymkent, 91 Turkestanskaya, tel.: 3-37-54
Д-р С.КРИВЦОВ	Главный врач, Районная глазная больница, Казахстан, Шымкент
Dr. S.KRIVTSOV	Head Physician, Regional Eye Hospital, Kazakhstan, Shymkent
Г-н Ж.УСЕНОВ	Начальник городского Управления здравоохранения, Областная Администрация, Казахстан, Шымкент, Свердлова 2, комната 2, тел.: (3252)3-79-70
Mr. Z.OUSENOV	Head of Finacial Department, Oblast Administration, Kazakhstan, Shymkent, 2 Sverdlova Street, room 2, tel.: (3252)3-79-70
Д-р М.МУМИНОВ	Директор, Частное малое предприятие "Сана", Казахстан, Шымкент, тел.: 3-53-61
Dr. M.MOUMINOV	Director, Private medical facility "Sana", Kazakhstan, Shymkent, tel.: 3-53-61
Г-н В.ГОРБУНОВ	Заместитель начальника Областного Управления Здравоохранения, Казахстан, Уральск, ул. Октябрьская 19, тел.: 2-16-36, факс: 2-16-36
Mr. V.GORBUNOV	Deputy Head of the Oblast Health Department, Kazakhstan, Uralsk, 19 Oktyabrskaya Street, tel.: 2-16-36, fax: 2-16-36
Г-н МЕЛКУНОВ	Казахстан
Mr. MELKUNOV	Kazakhstan
Г-жа Т.ДРАЧЕВА	Главный специалист, Упрравление здравоохранения, Казахстан, Шымкент
Ms. T.DRACHEVA	Chief specialist, Department of Health, Kazakhstan, Shymkent

Мадам С.БАРАХОВА	Заместитель главы администрации по социальным программам, Областная администрация, Казахстан, Шымкент
Madame S.BARAKHOVA	Deputy Oblast Head for social questions, Oblast Administration, Kazakhstan, Shimkent
Г-н Ж.УЖЕНОВ	Казахстан, Шымкент
Mr. Z.UZHENOV	Director, City HD, Kazakhstan, Shymkent
Г-жа Н.НИКОЛАЕВА	Казахстан, Шымкент
Ms. N.NIKOLAEVA	Kazakhstan, Shymkent
Д-р А.ВАГНЕР	Начальник, Математическая лаборатория симуляции, Казахстан
Dr. A.VAGNER	Head, Mathematican Simulation Laboratory, Kazakhstan
Д-р М.КУЛЬЖАНОВ	Заместитель министра, Министерство здравоохранения, Казахстан, Алматы
Dr. M.KULZHANOV	Deputy Minister, MOH, Kazakhstan, Almaty
Г-н Е.ИБРАЕВ	Начальник областного Управления Здравоохранения, Министерство Здравоохранения, Казахстан, Кокшетау, тел.: 4-11-53,4-31-03
Mr. Y.IBRAEV	Head of Kokshetau Regional Department of Health, Ministry of Health, Kazakhstan, Kokchetau, tel.: 4-11-53,4-31-03
Г-н У.АБИЛКАСЫМОВ	Министерство здравоохранения, Казахстан, Кокчетав
Mr. Y.ABILKASIMOV	MOH, Kazakhstan, Kokchetau
Г-жа Р.АБЗАЛОВА	Директор, Частный кардиологический центр, Казахстан, Жезказган, факс: (3102)73-43-66
Ms. R.ABZALOVA	Director, Private Cardiological Centre, Kazakhstan, Zhezkazgan, fax: (3102)73-43-66
Д-р А.ОКОНЕШНИКОВ	Министерство здравоохранения, Казахстан
Dr. A.OKONESHNIKOV	MOH, Kazakhstan
МЕРУЕРТ	Ассистент на конференции, Казахстан
MERUERT	Conference assistant, Kazakhstan
Г-н Б.АЖУЛИЕВ	Председатель, "БОБЕК", Казахстан, с.Георгиевка, Кирова, 40, тел.: 5-17-48
Mr. B.AZHULIYEV	Chairman, "Bobek", Kazakhstan, S.Kazakhstan obl, Georgievka, 40, Kirova, tel.: 5-17-48
Д-р П.ПЕТРОВ	Зам. Директора, НЦ МЭПЗ, Казахстан, Алматы, тел.: (3272)49-84-63
Dr. P.PETROV	Deputy Director, Scientific Centre, Kazakhstan, Almaty, tel.: (3272)49-84-63

Д-р К.АЯПОВ	Директор, Медицинский колледж, Казахстан, Алматы
Dr. K.AIAPOV	Director, Medical College, Kazakhstan, Almaty
Д-р К.АБДУЛЛИН	Министерство здравоохранения, Казахстан, Almaty
Dr. K.ABDOULLIN	MOH, Kazakhstan, Almaty
Д-р А.МЕДЕУОВ	Министерство здравоохранения, Казахстан, Шымкент
Dr. A.MEDEYOV	MOH, Kazakhstan, Shymkent
Д-р С.АРИСТАНОВА	Министерство здравоохранения, Казахстан, Алматы, тел.: (3272)33-17-25
Dr. S.ARYSTANOVA	MOH, Kazakhstan, Almaty, tel.: (3272)33-17-25
Д-р Н.АМИРЕЕВ	Председатель, Южно-Казахстанский Областной фонд медицинского страхования, Казахстан, Шымкент, тел.: 3-83-98
Dr. N.AMIREEV	Chairman, Oblast Fund BHI, Kazakhstan, Shymkent, tel.: 3-83-98
Д-р О.ЖУЗЖАНОВ	Директор, НЦ МЭПЗ, Казахстан, тел.: (3272)49-84-63
Dr. O.ZHOUZHANOV	Director, Scientific centre, Kazakhstan, tel.: (3272)49-84-63
Д-р В.ДЕВЯТКО	Министр, Министерство здравоохранения, Казахстан
Dr. V.DEVIATKO	Minister, Ministry of Health, Kazakhstan
Г-н М.ИБРАШЕВ	Казахстан
Mr. M.IBRASHEV	MHI Fund, Kazakhstan
Г-н БУЧЕВ	Зам. Директора Управления Здравоохранения, Казахстан, Уральск
Mr. BYACHEV	Deputy Head of the Health Dept., Kazakhstan, Uralsk
Г-н Б.АХМЕТОВ	Начальник, Областное Управление здравоохранения, Казахстан, Уральск, тел.: (31122)2-39, факс: 2-16-36
Mr. B.AKHMETOV	Head, Oblast Health Department, Kazakhstan, Uralsk, tel.: (31122)2-48-39, fax: 2-16-36
Г-н К.КАБИКЕНОВ	Заместитель начальника, Фонд медицинского страхования, Казахстан, Жезказган
Mr. K.KABIKENOV	Deputy Head, MHI Fund, Kazakhstan, Zhezkazgan
Г-н И.ЗАХАРОВ	Директор, Фонд медицинского страхования, Казахстан, Жезказган, тел.: (3102)73-41-38, факс: 73-40-15
Mr. I.ZAHAROV	Director, BHI Fund, Kazakhstan, Zhezkazgan, tel.: (3102)73-41-38, fax: 73-40-15

Д-р К.АЯПОВ	Директор, Медицинский колледж, Казахстан, Алматы
Dr. K.AIAPOV	Director, Medical College, Kazakhstan, Almaty
Д-р К.АБДУЛЛИН	Министерство здравоохранения, Казахстан, Almaty
Dr. K.ABDOULLIN	MOH, Kazakhstan, Almaty
Д-р А.МЕДЕУОВ	Министерство здравоохранения, Казахстан, Шымкент
Dr. A.MEDEYOV	MOH, Kazakhstan, Shymkent
Д-р С.АРИСТАНОВА	Министерство здравоохранения, Казахстан, Алматы, тел.: (3272)33-17-25
Dr. S.ARYSTANOVA	MOH, Kazakhstan, Almaty, tel.: (3272)33-17-25
Д-р Н.АМИРЕЕВ	Председатель, Южно-Казахстанский Областной фонд медицинского страхования, Казахстан, Шымкент, тел.: 3-83-98
Dr. N.AMIREEV	Chairman, Oblast Fund BHI, Kazakhstan, Shymkent, tel.: 3-83-98
Д-р О.ЖУЗЖАНОВ	Директор, НЦ МЭПЗ, Казахстан, тел.: (3272)49-84-63
Dr. O.ZHOUZHANOV	Director, Scientific centre, Kazakhstan, tel.: (3272)49-84-63
Д-р В.ДЕВЯТКО	Министр, Министерство здравоохранения, Казахстан
Dr. V.DEVIATKO	Minister, Ministry of Health, Kazakhstan
Г-н М.ИБРАШЕВ	Казахстан
Mr. M.IBRASHEV	MHI Fund, Kazakhstan
Г-н БУЧЕВ	Зам. Директора Управления Здравоохранения, Казахстан, Уральск
Mr. BYACHEV	Deputy Head of the Health Dept., Kazakhstan, Uralsk
Г-н Б.АХМЕТОВ	Начальник, Областное Управление здравоохранения, Казахстан, Уральск, тел.: (31122)2-48-39, факс: 2-16-36
Mr. B.AKHMETOV	Head, Oblast Health Department, Kazakhstan, Uralsk, tel.: (31122)2-48-39, fax: 2-16-36
Г-н К.КАБИКЕНОВ	Заместитель начальника, Фонд медицинского страхования, Казахстан, Жезказган
Mr. K.KABIKENOV	Deputy Head, MHI Fund, Kazakhstan, Zhezkazgan
Г-н И.ЗАХАРОВ	Директор, Фонд медицинского страхования, Казахстан, Жезказган, тел.: (3102)73-41-38, факс: 73-40-15
Mr. I.ZAHAROV	Director, BHI Fund, Kazakhstan, Zhezkazgan, tel.: (3102)73-41-38, fax: 73-40-15

Г-н И.БАЙДАУЛЕТОВ	Главный врач, Медико-санитарная часть "ФОСФОР", Казахстан, Шымкент
Mr. I.BAIDAYLETOV	Chief Physicist, Medical department "PHOSPHOR", Kazakhstan, Shymkent
Г-н Х.ЖИГИТАЕВ	Начальник, Областное Управление здравоохранения, Казахстан, Усть-Каменогорск, тел.: 66-32-63
Mr. H.ZHIGITAEV	Head, Oblast Health Department, Kazakhstan, Ust-Kamenogorsk, tel.: 66-32-63
Г-жа М.ТУСЕЕВА	Начальник управления социальной сферы и науки, Министерство финансов, Казахстан, тел.: (3272)62-25-79
Ms. M.TUSEEVA	Head of Social Sphere and Science, Ministry of Finance, Kazakhstan, tel.: (3272)62-25-79
Г-н К.ЕЛЬЖАНОВ	Заместитель начальника, Областное Управление здравоохранения, Казахстан, Атырау
Mr. K.ELZHANOV	Deputy Head, Oblast, Kazakhstan, Atyrau
Г-жа Г.НОКИНА	Главный специалист отдела медицинского страхования, Министерство здравоохранения, Казахстан, Алматы, тел.: (3272)33-48-31
Ms. G.NOKINA	MOH, Kazakhstan, Almaty, tel.: (3272)33-48-31

Kyrgyzstan

Д-р КАСИЕВ	Министр, Министерство здравоохранения, Кыргызстан, Бишкек, Манаса 125-5, тел.: (3312)26-33-65, факс: 22-84-24
Dr. N.KASIEV	Minister, Ministry of Health Care, Kyrgyzstan, Bishkek, Manasa125-5, tel.: (3312)26-33-65, fax: 22-84-24
Г-н К.БАЙСЕРКАЕВ	Директор, Институт менеджмента, Кыргызстан, Каракол
Mr. K.BAISERKAEV	Director, Institute of menegement, Kyrgyzstan, Karakol
Г-н О.БЕРДИКОЖОЕВ	Министерство здравоохранения, Кыргызстан
Mr. O.BERDIKOZHOEV	MOH, Kyrgyzstan
Г-жа С.АСАНХОДЖАЕВА	Министерство здравоохранения, Кыргызстан
Ms. S.ASANHODZHAEVA	MOH, Kyrgyzstan
Г-н М.КАРАТАЕВ	Координатор Технического координационного Совета, Министерство здравоохранения, Кыргызстан, Бишкек, Берегового 16, тел.: (3312)22-32-96
Mr. M.KARATAEV	Coordinator of Technical Coordination Council, MOH, Kyrgyzstan, Bishkek, Beregiovaya 16, tel.: (3312)22-32-96
Г-н А.ИСМАНКУЛОВ	Директор, Научно-Исследовательский Центр офтальмологии, Кыргызстан, Бишкек, ул. Советская 170, комнаты 34-48, тел.: 26-34-84
Mr. A.ISMANKOULOV	Director, Scientific-Search Centre of ophtalmology, Kyrgyzstan, Bishkek, 170 Sovetskaya Str., room 34-48, tel.: 26-34-84
Г-жа Б.КАЛИЕВА	Заместитель министра, Министерство здравоохранения, Кыргызстан, Бишкек, Городская 33-7, тел.: (3312)24-84-11
Dr. B.KALIEVA	Deputy Minister, Ministry of Health, Kyrgyzstan, Bishkek, Gorodskaya 33-76, tel.: (3312)24-84-11
Г-н К.АХМАТБЕКОВ	Начальник Управления, Управление здравоохранения Нарынской Области, Кыргызстан, Нарын, тел.: 2-47-01
Mr. K.AHMATBEKOV	Head, Health Administration of Naryn Oblast, Kyrgyzstan, Naryn, tel.: 2-47-01
Г-жа М.АТАБЕКОВА	Президент, Ассоциация Врачей и фармацевтов, Кыргызстан, тел.: 22-15-07
Ms. M.ATABEKOVA	President, Association of Physitians and Pharmaceutists, Kyrgyzstan, tel.: 22-15-07
Г-н А.ЧУКУШЕВ	Главный Врач, Чуйская Областная больница, Кыргызстан, тел.: 3-34-45
Mr. A.CHUKUSHEV	Chief Physician, Oblast Hospital, Kyrgyzstan, tel.: 3-34-45
Г-н Ж.ЖИЕНБАЕВ	Начальник, Областное финансовое Управление здравоохранения, Кыргызстан, Бишкек, Московская 690-87, тел.: (3312)34-67-82
Mr. Z.ZHIENBAEV	Head, Oblast Health Finance, Kyrgyzstan, Bishkek, Moskovskaya 690-87, tel.: (3312)34-67-82

Д-р Ш.АБДРАЕВА	Начальник, Областное Управление здравоохранения, Кыргызстан, Каракол, Толкогулова 78-5, тел.: (31922)2-23-45
Dr. S.ABDRAEVA	Chief, Oblast Health Department, Kyrgyzstan, Karakol, Toktogul Str. 78-5, tel.: (31922)2-23-45
Г-н Н.ИСАКОВ	Начальник отдела неправительственных медицинских средств, Министерство здравоохранения, Кыргызстан, Бишкек, Богембая 28-96, тел.: (3312)25-45-22
Mr. N.ISAKOV	Head of non-goverment medical facilites department, MOH, Kyrgyzstan, Bishkek, Bogembai 28-96, tel.: (3312)25-45-22
Г-н Г.ГЕДИК	Министерство здравоохранения, Кыргызстан, тел.: (3312)22-03-08, факс: (3312)22-32-95
Mr. G.GEDIK	MOH, Kyrgyzstan, tel.: (3312)22-03-08, fax: (3312)22-32-95
Г-н А.КОЖАЛИЕВ	Главный врач, Джалалабадская областная больница, Кыргызстан, Джалалабад, тел.: 3-31-95
Mr. A.KOZHALIEV	Chief Physician, Oblast Hospital, Kyrgyzstan, Dzhalalabad, tel.: 3-31-95
Г-жа Н.КУМСКОВА	Заведующая кафедрой экономической теории и менеджмента, Кыргызский Государственный Университет, Кыргызстан, тел.: 42-58-06
Ms. N.KUMSKOVA	Head the Economic theory and menegement Department, Kyrgyz State University, Kyrgyzstan, tel.: 42-58-06
Д-р Г.АШИРАХМАНОВА	Председатель, Ассоциация врачей, Киргизия, Каракол, Ленина 45/24, тел.: (31922)2-24-53
Dr. G.ASHIRAKHMANOVA	Chairman, Assosiation of Physicians, Kyrgyzstan, Karakol, Lenin 45/24, tel.: (31922)2-24-53
Д-р Б.КУРМАНАЛИЕВ	Главный Врач, Областная больница, Кыргызстан, Каракол, Ленинского Комсомола 2, тел.: 2-05-81
Dr. B.KURMANALIEV	Chief Physician, Oblast Hospital, Kyrgyzstan, Karakol, 2 Leninskogo Komsomola, tel.: 2-05-81
Д-р К.РЫСБАЕВ	Областной заместитель, Министерство здравоохранения, Кыргызстан, Каракол, Дзержинского 672-31, тел.: (31922)2-41-77
Dr. K.RYSBAEV	Oblast Deputy, Ministry of Health, Kyrgyzstan, Karakol, Dzerzhinski 672-31, tel.: (31922)2-41-77
Д-р М.ЧАМАЧЕВ	1-й заместитель Главы, Иссыкульская Областная Администрация, Кыргызстан, Каракол, Алмалыкская 42-2, тел.: (31922)3-24-46
Dr. M.CHAMACHEV	1-st Deputy Head, Issyk-Kul Oblast Administration, Kyrgyzstan, Karakol, Almalik Str. 42-2, tel.: (31922)3-24-46
Д-р Т.МЕЙМАНАЛИЕВ	Директор Технического координационного Комитета, Министерство здравоохранения, Кыргызстан, Бишкек, Фрунзе 67-54, тел.: (3312)26-33-65
Dr. T.MEIMANALIEV	Director of Technical Coordination Committee, Ministry of Health Care, Kyrgyzstan, Bishkek, Frunze 67-54, tel.: (3312)26-33-65
Д-р Д.САЛИЕВА	Начальник, Областное Управление здравоохранения, Кыргызстан, Каракол, Красногвардейский 673-22, тел.: (31922)2-45-53
Dr. D.SALIEVA	Chief, Oblast Health Department, Kyrgyzstan, Karakol, Krasnogvardeiskiy 673-22, tel.: (31922)2-45-53
Д-р А.ШАЯХМЕТОВА	Начальник отдела медицинского страхования, Министерство здравоохранения, Кыргызстан, Бишкек, Бегалина 43-9, тел.: (3312)22-32-95
Dr. A.SHAYAKHMETOVA	Head of Helth Insurance Department, MOH, Kyrgyzstan, Bishkek, Begalina 43-9, tel.: (3312)22-32-95

Г-жа С.РЫСАЛИЕВА	Начальник Управления, Министерство финансов, Кыргызстан
Ms. S.RYSALIEVA	Head of the Department, Ministry of Finance, Kyrgyzstan
Г-жа О.ТАЗАБЕКОВА	Заместитель Главного врача, Вторая Республиканская больница, Кыргызстан, тел.: (3312)22-89-60
Ms. O.TAZABEKOVA	Deputy Chief Physician, Republic Hospital No.2, Kyrgyzstan, tel.: (3312)22-89-60
Г-жа Л.ЗАБИРОВА	Начальник Управления социальной сферы, Государственный Комитет по экономике, Кыргызстан, тел.: 26-42-17
Ms. L.ZABIROVA	Head of the Department of Social Sphere, State Economic Committee, Kyrgyzstan, tel.: 26-42-17
Г-жа С.УКУШЕВА	Заведующая Первомайским райфинанотделом, Министерство финансов, Кыргызстан, Бишкек, Жибек-Жолы 348, комната 9, тел.: 22-15-71, факс: 62-09-55
Ms. S.UKUSHEVA	Head of the Regional Department of Finance, Ministry of Finance, Kyrgyzstan, Bishkek, 348 Zhybek-Zholy Str., room 9, tel.: 22-15-71, fax: 62-09-55
Г-н М.ИЯЗАЛИЕВ	Министерство здравоохранения, Кыргызстан
Mr. M.IYAZALIEV	МОН, Kyrgyzstan
Г-жа Г.НАЗАРКИНА	Заместитель начальника, Финансовое Управление здравоохранения, Кыргызстан, Бишкек, Белинского 12, тел.: 21-33-22, факс: 21-33-24
Ms. G.NAZARKINA	Deputy Head, Finance Helth Department, Kyrgyzstan, Bishkek, 12 Belinskogo Street, tel.: 21-33-22, fax: 21-33-24
Г-н С.ЧЫНЫБАЕВ	Главный Врач, Джеты-Огузская районная больница, Кыргызстан, Ысык-Куль, ул. Комсомольская 90, тел.: 2-16-42
Mr. S.SHYNYBAEV	Chief Physician, Dzheti-Ogyz Regional Hospital, Kyrgyzstan, Ysyk-Kol, 90 Komsomolskaya Street, tel.: 2-16-42

Moldova

Д-р А.РУССУ	Директор, Управление мед. страхования и реформ, Молдова
Dr. A.RUSSU	Director, Department for medical assistance, insurance, Moldova

Russia

Д-р Р.ЗЕЛКОВИЧ	Директор, Областной Информационный Центр, Россия, 650036, Кемерово, Волгоградская 43, тел.: (3842)55-73-70
Dr. R.ZELKOVICH	Dierctor, Oblast Information Centre, Russia, 650036, Kemerovo, 43 Volgogradskaya, tel.: (3842)55-73-70
Д-р А.ТРАУТЕР	Глава, Территориальный Фонд Медицинского Страхования, Россия, 650027, Кемерово, Красноармейская 136, тел.: (3842)23-17-06
Dr. A.TRAUTER	Head, Territorial BHI Fund, Russia, 650027, Kemerovo, 136 Krasnoarmeyskaya, tel.: (3842)23-17-06
Д-р Н. МАТВЕЕВА	Главный экономист, Территориальный Фонд Обязательного Медицинского Страхования, Россия, Кемерово
Dr. N. MATVEEVA	Chief Economist, Territorial MHI Fund, Russia, Kemerovo
Д-р А.ИВАНИНСКАЯ	Директор, Страховая компания "АСОПО-ЖИЗНЬ", Россия, 630099, Новосибирск, Красный проспект 42, тел.: (3832)22-29-31
Dr. A.IVANINSKAYA	Director, Insurance company "ASOPO-ZHIZN", Russia, 630099, Novosibirsk, 42 Krasny pr., tel.: (3832)22-29-31
Г-жа Н.ВОВКЕДОВ	Россия
Ms. N.VOVKEDOV	Russia
Д-р В.ШЕВСКИЙ	Заместитель начальника, Комитет здравоохранения, Россия, 443010, Самара, Чапаевская 181
Dr. V.SHEVSKY	Deputy Head, Health Care Committee, Russia, 443010, Samara, 181 Chapaevskaya str.
Д-р Н.НЕЛЕПИНА	Директор, Страховая компания "КУЗБАСС", Россия, 650099, Кемерово, Островского 16, тел.: (3842)36-86-94
Dr. N.NELEPINA	Director, "Kuzbass" insurance company, Russia, 650099, Kemerovo, 16 Ostrovskogo, tel.: (3842)36-86-94
Д-р В.ОМЕЛЬЧЕНКО	Глава Комитета, Комитет здравоохранения, Россия, 248640, Калуга, Набережная 4
Dr. V.OMELCHENKO	Head of Committee, Health Care Committee, Russia, 248640, Kaluga, 4 Naberezhnaya str.
Г-жа Н.КРЕМЛЕВА	Начальник Управления, Областной Фонд Медицинского Страхования, Россия, Калуга
Ms. N.KREMLOVA	Chief of Department, Oblast MHI Fund, Russia, Kaluga
Д-р Л.СЕДАЧЕВА	Зам. Главврача, Районная больница, Россия, Кемерово, Октябрьский пр-т, 49-23, тел.: (3842)52-25-10
Dr. L.SEDACHEVA	Deputy Chief Doctor, Regional Hospital, Russia, Kemerovo, 49 Oktyabrskii prospekt #23, tel.: (3842)52-25-10
Д-р В.СЕМЕНОВ	Первый заместитель Главы, Федеральный Фонд Обязательного Медицинского Страхования, Россия, 101481, Москва, Новослободская 37
Dr. V.SEMENOV	First Deputy Head, Federal MHI Fund, Russia, 101481, Moscow, 37 Novoslobodskaya

Д-р Б.СЕРЫХ	Главный врач, Областная больница учителей, Россия, Томск
Dr. B.SERYK	Chief Doctor, Oblast Teaching Hospital, Russia, Tomsk
Г-н М.ТУБЕНСЛАГ	Россия
Dr. M.TUBENSLAG	Russia
Г-н П.КОПОСОВ	Федеральный Фонд Обязательного Медицинского Страхования, Россия, 101481, Москва, Новослободская 37
Mr. P.KOPOSOV	Federal Fund, Russia, 101481, Moscow, 37 Novoslobodskaya
Д-р Т.ФОМИНА	Зам. Главврача, Гор. больница, Россия, Томск, Сибирская 31 - 82, тел.: (3822)26-14-64
Dr. T.FOMINA	Deputy Chief doctor, City Hosp No.3, Russia, Tomsk, 31 Sibirskaya, 82, tel.: (3822)26-14-64
Г-н Д.СОКОЛ	Россия
Mr. D.SOKOL	Russia
Д-р А.ЗЛОБИН	Глава Территориального Фонда, Фонд обязательного Медицинского Страхования, Россия, 170000, Тверь, Володарского 24
Dr. A.ZLOBIN	Head of Territorial Fund, MHI Fund, Russia, 170000, Tver, 24 Volodarskogo
Д-р Г.ЦАРИК	Директор, Институт здоровья и Социальных проблем, Россия, 650036, Кемерово, Волгоградская 43, тел.: (3842)55-19-89
Dr. G.TSARIK	Director, Inst.of Health and Soc.Problems, Russia, 650036, Kemerovo, 43 Volgogradskaya, tel.: (3842)55-19-89
Д-р В.МАЛЕНЧЕНКО	Директор, Областной Комитет здравоохранения, Россия, 650099, Кемерово, пр. Советский 55, тел.: (3842)36-42-84
Dr. N.MALENCHENKO	Head, Oblast Health Committe, Russia, 650099, Kemerovo, 58 Sovetsky pr., tel.: (3842)36-42-84
Д-р В.ЧИГАНОВ	Россия
Dr. V.CHIGANOV	Russia

Russia/ZdravReform Program

Д-р Д.РАЙС	Директтор регионального офиса, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Россия, 117409, Москва, Ленинский проспект, 2, тел.: (095)956-78-17, факс: (095)956-78-18
Dr. J.RICE	Country Director, ZdravReform Program/Abt Associates Inc., Russia, 117409, Moscow,Leninsky prospect,2, tel.: (095)956-78-17, fax: (095)956-78-18
Д-р Д.ЛАНГЕНБРУННЕР	Экономист, Программа ЗдравРеформ/АБТ Ассоусиэйтс, США, 117409, Москва, Ленинский проспект 2, тел.: (095)956-78-17, факс: (095)956-78-18
Dr. J.LANGENBRUNNER	Economist, ZdravReform Program/Abt Associates Inc., U.S., 117409, Moscow, 2 Leninsky prospect, tel.: (095)956-78-17, fax: (095)956-78-18
Г-жа К.ПОЭР	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Россия, 117409, Москва, Ленинский проспект, 2, тел.: (095)956-78-17, факс: (095)956-78-18
Ms. K.POER	ZdravReform Program/Abt Associates Inc., Russia, 117409, Moscow, 2 Leninsky prospect, tel.: (095)956-78-17, fax: (095)956-78-18
Д-р Т.МАКАРОВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Россия, 117409, Москва, Ленинский проспект, 2, тел.: (095)956-78-17, факс: (095)956-78-18
Dr. T.MAKAROVA	ZdravReform Program/Abt Associates Inc., Russia, 117409, Moscow, 2 Leninsky prospect, tel.: (095)956-78-17, fax: (095)956-78-18
Д-р Л.МИЛБУРН	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Россия, 630099, Новосибирск, Чаплыгина 75, тел.: (3832)23-94-94, факс: (3832)23-84-78
Dr. L.MILBURN	ZdravReform Program/Abt Associates Inc., Russia, 630099, Novosibirsk, 75 Chaplygina St., tel.: (3832)23-94-94, fax: (3832)23-84-78
Г-жа С.РАГИМОВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Россия, 630099, Новосибирск, Чаплыгина 75, тел.: (3832)23-94-94, факс: (3832)23-84-78
Ms. S.RAGIMOVA	ZdravReform Program/Abt Associates Inc., Russia, 630099, Novosibirsk, 75 Chaplygina St, tel.: (3832)23-94-94, fax: (3832)23-84-78
Г-жа Г.КОШЕЛЕВА	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Россия, 117409, Москва, Ленинский проспект, 2, тел.: (095)956-78-17, факс: (095)956-78-18
Ms. G.KOSHELEVA	ZdravReform Program/Abt Associates Inc., Russia, 117409, Moscow, 2 Leninsky prospect, tel.: (095)956-78-17, fax: (095)956-78-18
Д-р Р.ХАЛЕЙ	Программа ЗдравРеформ/Девелопмент Ассоусиэйтсс Инк., Россия, 630099, Новосибирск, Чаплыгина 75, тел.: (3832)23-94-94, факс: (3832)23-84-78
Dr. R.WHALEY	ZdravReform Program/Development Associates Inc., Russia, 630099, Novosibirsk, 75 Chaplygina St., tel.: (3832)23-94-94, fax: (3832)23-84-78
Д-р С.ТИЛЛИНГХЭСТ	Программа ЗдравРеформ/Е.Петриш и Ассоусиэйтсс Инк., Россия, 630099, Новосибирск, Чаплыгина 75, тел.: (3832)23-94-94, факс: (3832)23-84-78
Dr. S.TILLINGHAST	ZdravReform Program/E.Petrich and Associates Inc., Russia, 630099, Novosibirsk, 75 Chaplygina St., tel.: (3832)23-94-94, fax: (3832)23-84-78

Tadjikistan

Г-жа З.МИРЗОЕВА	Заместитель министра здравоохранения, Министерство Здравоохранения, Таджикистан
Ms. Z.MIRZOEVA	Deputy Minister, Ministry of Health Care, Tadjikistan
Г-н Н.РАДЖАБОВ	Начальник Управления здравоохранения, Управление здравоохранения Халтонской области, Таджикистан
Mr. N.RAJABOV	Head of the Department, Department of Health of Khalton Olast, Tadjikistan
Д-р Д.И.ИНОМЗОДА	Председатель, ЦК профсоюза работников здравоохранения, Таджикистан, Душанбе, тел.: (3772)21-38-82
Dr. D.I.INOMZODA	Chairman, Trade Union of Helth Workers, Tadjikistan, Dushanbe, tel.: (3772)21-38-82
Г-н Х.РУФИЕВ	Начальник Управления здравоохранения, Управления здравоохранения Ходжантской области, Таджикистан
Mr. H.RUFIEV	Head of the Department, Department of Health of Khojant Olast, Tadjikistan
Г-н З.САНГИНОВ	Начальник, Душанбинское городское Управление здравоохранения, Таджикистан, Душанбе
Mr. Z.SANGINOV	Head of the Department, Dushanbe City Health Department, Tadjikistan, Dushanbe
Д-р Т.НОРКУЛОВ	Министерство здравоохранения, Таджикистан, факс: 21-75-25
Dr. T.NOURKULOV	MOH, Tadjikistan, fax: 21-75-25

Turkmenistan

Г-жа Г.ИСМАИЛОВА	Начальник Планового и Финансового Отдела, Министерство Здравоохранения, Туркменистан
Ms. G.ISMAILOVA	Head of Planning and Finance Department, Ministry of Health, Turkmenistan
Г-жа Н.ИСМАИЛОВА	Министерство Здравоохранения, Туркменистан
Ms. N.ISMAILOVA	MOH, Turkmenistan
Г-жа И.БОГОМОЛОВА	Руководитель подразделения по вопросам здравоохранения, Министерство Финансов, Туркменистан
Ms. I.BOGOMOLOVA	Head of Subdivision of HC Finance, Ministry of Finance, Turkmenistan
Г-жа Ф.ФАХРИТДИНОВА	Начальник Главного финансового отдела, Министерство Социальной Защиты, Туркменистан
Ms. F.FAHRITDINOVA	Head of main Finance Department, Ministry of Social Protection, Turkmenistan
Г-н Б.ШАХМУРАДОВ	Начальник отдела планирования, Управление здравоохранения городской администрации, Туркменистан, Ашгабад, тел.: 25-40-70
Mr. B.SHAHMURADOV	Head of Planning sector, Health Department of City Administration, Turkmenistan, Ashgabat, tel.: 25-40-70
Г-жа О.АННАМУХАМЕДОВА	Заместитель министра, Министерство Экономики и финансов, Туркменистан, Ашгабад, ул. Поммы 4, комната 63, тел.: (3772)29-35-30
Ms. O.ANNAMUKHAMEDOVA	Deputy Minister, Ministry of Economy and Finance, Turkmenistan, Ashgabat, 4 Pomma Str., room 63, tel.: (3772)29-35-30
Г-н А.НАЗАРОВА	Консультант отдела Здравоохранения, Кабинет Министров, Туркменистан, Ашгабад, Гоголя 17, комната 48, тел.: (3632)35-11-61, факс: 35-51-12
Mr. A.NAZAROVA	Health Care Department, Consultant, Cabinet of Ministers, Turkmenistan, Ashgabat, 17 Gogol Str., room 48, tel.: (3632)35-11-61, fax: 35-51-12
Г-жа О.ПЫШТИЕВА	Депутат, Зам.председателя Комитета экономике, Меджилис, Туркменистан, Ашгабад, Гоголя 17, тел.: 39-59-57, факс: 35-51-12
Ms. O.PYSHTIEVA	Deputy, Member ofCommittee in Economic, Medjilis, Turkmenistan, Ashgabat, 17 Gogol Street, tel.: 39-59-57, fax: 35-51-12
Г-жа И.АРУШАНЯН	Министерство здравоохранения, Туркменистан, Ашгабат, тел.: (3632)24-97-01, факс: (3632)24-11-93
Ms. I.ARUSHANYAN	MOH, Turkmenistan, Ashgabat, tel.: (3632)24-97-01, fax: (3632)24-11-93

Ukraine

Д-р А.ЛИТВАК	Украина, Одесса
Dr. A.LITVAK	MOH, Ukraine, Odessa
Д-р В.ЛЕХАН	Директор, Управление здравоохранения, Украина, Днепропетровск
Dr. V.LEHAN	Директор, Department of health care management, Ukraine, Dnepropetrovsk
И.ПАЛАМАР	Украина
I.PALAMAR	Ukraine
Д-р И.СОЛОНЕНКО	Академия руководителей общественности, Украина, Киев
Dr. I.SOLONENKO	Academy of Public Administration, Ukraine, Kiev
Д-р Д.ДЖАФАРОВА	Главный врач, Городская больница №1, Украина, Львов, Болгарская 1-6, тел.: 34-04-91
Dr. J.JAFAROVA	Chief doctor, City Hospital, Ukraine, Lviv, 1 Bolgarska Str., 6, tel.: 34-04-91
Л.ЗАХАРИА	Украина
L.ZAHARIA	Ukraine
Г-н В.ОЛМЕНЧЕНКО	Украина
Mr. V.OLMENCHENKO	Ukraine
Д-р А.ХАПИН	Главврач, Родильный дом № 1, Украина, Одесса
Dr. A.HAPIN	Chief Physitian, Maternity Hospital № 1, Ukraine, Odessa
Г-жа Л.МАЦАЛЫЩЕНКО	Украина
Ms. L.MATSALYSHCHENKO	Deppute Chief Physitian, Ukraine
Ю.КАРПОВСКИЙ	Украина
Y.KARPORSKY	Ukraine
Г-жа Л.ТРУШКИНА	Главный Экономист, Областная поликлиника, Украина, Одесса
Ms. L.TRUSHKINA	Chief Economist, Oblast Polyclinic, Ukraine, Odessa

Г-н С.КОЛЕСНИК	Украина
Mr. S.KOLESNIK	Ukraine
Д-р. А.СТЕПАНЕНКО	Институт здравоохранения, Украина, Киев
Dr. A.STEPANENKO	National institute of health, Ukraine, Kiev
Д-р Е.ПОЛАТАЙКО	Главный врач, Городская больница №2, Украина, Львов, Потебинская 3, тел.: 67-05-74
Dr. E.POLATAIKO	Chief Doctor, City Polyclinic №2, Ukraine, Lviv, 3 Potebni St., tel.: 67-05-74
И.ДЕРШКО	Начальник здравоохранения, Областная Администрация, Украина, Львов, Конопнитская 3 тел.: 76-45-81
I.DERSHKO	Chief, Oblast Health Administration, Ukraine, Lviv, 3 Konopnytska, tel.: 76-45-81
Г-н Я.БАЗИЛЕВИЧ	Декан факультета медицинских руководителей, Медицинский Университет, Украина, Львов, Гринвальдская 8-7, тел.: 35-30-28
Mr. Y.BAZYLEVYCH	Chairman of Faculty of Health Administration, Medical University, Ukraine, Lviv, 8 Grunvaldska St.,7, tel.: 35-30-28
Д-р В.ВЕРЕС	Главный Врач, Районная больница, Украина, Жовква, Лисна 5, тел.: 2-11-61
Dr. V.VERES	Chief Doctor, Rayon Hospital, Ukraine, Zhovkva, Lisna St.5, tel.: 2-11-61
Г-н Ю.ПРОКОПЧУК	Медицинская Академия, Украина, Днепропетровск
Mr. Y.PROKOPCHUK	Academy of Medicine, Ukraine, Dnepropetrovsk
Г-жа С.БЫЧЕНКО	Экономист, Городская больница №1, Украина, Львов, Ворошилова 26-44
Ms. S.BYCHENKO	Economist, City Hospital №1, Ukraine, Lviv, 26 Voroshilova, 44
Г-жа О.СКНАРИНА	Главный бухгалтер, Областная поликлиника, Украина, Одесса
Ms. O.SKNARINA	Cheef Accountant, Oblast Polyclinic, Ukraine, Odessa
Д-р А.ШУБИН	Главврач, Городская поликлиника, Украина, Одесса
Dr. A.SHUBIN	Chief Doctor, City Polyclinic, Ukraine, Odessa

Ukraine/ZdravReform Program

Г-н Т.ВИТТЕНБЕРГ	Директор регионального офиса, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, 270035, Одесса, Канатная, 134, тел.: (0482)22-70-41, факс: (0482)28-43-10
Mr. T.WITTENBERG	Regional director, ZdravReform Program/Abt Associates Inc., Ukraine, 270035, Odessa, 134 Kanatnaya, tel.: (0482)22-70-41, fax: (0482)28-43-10
Д-р М.СТОУН	Директор регионального офиса, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, 252001, Киев, Крещатик 29-50, тел.: (38044)462-0366, факс: (38044)224-6189
Dr. M.STONE	Regional Director, ZdravReform Program/Abt Associates Inc., Ukraine, 252001, Kiev, 29 Kreschatik St.,50, tel.: (38044)462-0366, fax: (38044)224-6189
Г-н Дж.СТИВЕНС	Технический консультант, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, Львов
Mr. J.STEVENS	Office Technical Advisor, ZdravReform Program/Abt Associates Inc., Ukraine, Lviv
Г-н Р.ПОНОС	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, 252001, Киев, Крещатик 29-50, тел.: (38044)462-0366, факс: (38044)224-6189
Mr. R.PONOS	ZdravReform Program/Abt Associates Inc., Ukraine, 252001, Kiev, 29 Kreschatik St.,50, tel.: (38044)462-0366, fax: (38044)224-6189
Г-жа К.СТИВЕНС	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, 252001, Киев, Крещатик 29-50, тел.: (38044)462-0366, факс: (38044)224-6189
Ms. C.STEVENS	ZdravReform Program/Abt Associates Inc., Ukraine, 252001, Kiev, 29 Kreschatik St.,50, tel.: (38044)462-0366, fax: (38044)224-6189
Д-р. Б.УСПЕНСКИЙ	Консультант по медицинским вопросам, Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, Львов
Dr. B.USPENSKY	Office Medical Consultant, ZdravReform Program/Abt Associates Inc., Ukraine, Lviv
Г-жа Л.ТРУХАН	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, 252001, Киев, Крещатик 29-50, тел.: (38044)462-0366, факс: (38044)224-6189
Ms. L.TRUHAN	ZdravReform Program/Abt Associates Inc., Ukraine, 252001, Kiev, 29 Kreschatik St.,50, tel.: (38044)462-0366, fax: (38044)224-6189
Г-жа Дж.ЛИСФЕЛТ	Программа ЗдравРеформ/АБТ Ассоусиэйтс, Украина, 252001, Киев, Крещатик 29-50, тел.: (38044)462-0366, факс: (38044)224-6189
Ms. J.LISSFELT	ZdravReform Program/Abt Associates Inc., Ukraine, 252001, Kiev, 29 Kreschatik St.,50, tel.: (38044)462-0366, fax: (38044)224-6189

Uzbekistan

Г-жа О.АБДУЛАЕВА	1-й Заместитель Министра, Министерство Социального Обеспечения, Узбекистан, Ташкент, Абдул-Авлони 20, комната 24, тел.: 53-18-00
Ms. O.ABDULLAEAVA	1-st Deputy Minister, Ministry of Social Protection, Uzbekistan, Tashkent, 20 Abdul-Avloni, room 24, tel.: 53-18-00
Г-н А.НАЗАРОВ	Директор, Частная клиника "АНИК", Узбекистан, Ташкент, ул. Бобур 45, комната 33, тел.: 53-36-43
Mr. A.NAZAROV	Director, Private Medical Hospital "Anik", Uzbekistan, Tashkent, 45 Bobur Str., room 33, tel.: 53-36-43
Г-н М.АБДУРАХИМОВ	Заместитель начальника, Ферганское областная Управление здравоохранения, Узбекистан, Фергана
Mr. M.ABDURAHIMOV	Deputy Head, Fergana Regional HC Administration, Uzbekistan, Fergana
Г-н Х.КАРИМОВ	Президент, Государственная медицинская школа №2, Узбекистан
Mr. H.KARIMOV	President, State medical School №2, Uzbekistan
Г-н ДЖАРКУЛОВ	Заместитель министра, Министерство здравоохранения, Узбекистан
Mr. JARKULOV	Deputy Minister, MOH, Uzbekistan
Г-н К.АКРАМОВ	Главный врач, 1-я клиника второго Государственного Мед.Института, Узбекистан, Ташкент
Mr. K.AKRAMOV	Chief Physician, 1-st clinic of second State Medicine Institute, Uzbekistan, Tashkent
Г-н Л.СУЛТАНОВ	Заместитель министра, Министерство здравоохранения, Узбекистан, Ташкент, Заравшана 10-76, тел.: (3712)44-26-03
Mr. L.SULTANOV	Deputy Minister, MOH, Uzbekistan, Tashkent, Zaravashan 10-76, tel.: (3712)44-26-03
Г-н С.АРИФОВ	Координатор, Чикаго!Ташкентский госпиталь, Узбекистан, Ташкент, Свердловская 56-22, тел.: (3712)44-26-03, факс: (3712)78-48-69
Mr. S.ARIFOV	Coordinator, Partnership Hospital, Uzbekistan, Tashkent, Sverdlovskaya 56-22, tel.: (3712)44-26-03, fax: (3712)78-48-69
Г-н С.АБДУЛАЕВ	Заместитель министра финансов, Министерство финансов, Узбекистан, Ташкент, Мустакиллик Площадь 5, комната 713, тел.: (3712)39-10-20
Mr. S.ABDULLAEV	Deputy Minister of Finance, Ministry of Finance, Uzbekistan, Tashkent, 5 Mustakillik Square, room 713, tel.: (3712)39-10-20
Д-р А.ПОГОРЕЛОВА	Директор, Центр оздоровления и реабилитации женщин фертильного возраста, Узбекистан
Dr. A.POGORELOVA	Director, Health Centre for women, Uzbekistan
Г-жа Л.АМБАРЦУМОВА	Начальник Управления по Физической Культуры, Министерство Здравоохранения, Узбекистан
Ms. L.AMBARSUMOVA	Head of Department of Physical Culture, Ministry of Health Care, Uzbekistan

Г-н А.УТЕНАЗАРОВ	Заместитель Министра, Каракалпакское Министерство Здравоохранения, Узбекистан, Каракалпакстан, Нукус, тел.: 4-35-39
Mr. A.UTENAZAROV	Deputy Minister, Ministry of HC of Karakalpakstan, Uzbekistan, Karakalpakstan, Nykus, tel.: 4-35-.
Г-жа Р.САРЫМСАКОВА	Начальник Планового Сектора, Ташкентское региональное отделение здравоохранения, Узбекистан, Ташкент
Ms. R.SARYMSAKOVA	Head of Planning Sector, Tashkent Regional HC Department, Uzbekistan, Tashkent
Д-р Э.РАХИМОВ	Советник по экономическим вопросам, Министерство Здравоохранения, Узбекистан
Dr. E.RAKHIMOV	Economic Adviser, Ministry of Health Care, Uzbekistan
Г-н Ю.КАДЫРОВ	Заместитель руководителя отдела по экономическим вопросам, Министерство Здравоохранения, Узбекистан, Ташкент, ул. Навои 12, комната 8, тел.: 41-86-12
Mr. Y.KADYROV	Deputy Head of Economic Department, Ministry of Health Care, Uzbekistan, Tashkent, 12 Navoi Str., room 8, tel.: 41-86-12
Г-н НИУЗАМОВ	Главный специалист Научного Отдела, Ташкентский Хоккимиат, Узбекистан, Ташкент
Mr. R.NIUZAMOV	Chief specialist of Scientific Department, Tashkent Hokimiyat, Uzbekistan, Tashkent
Д-р Ш.КАРИМОВ	Министр, Министерство здравоохранения, Узбекистан, Ташкент, Навои 123-92, тел.: (3712)41-17-52
Dr. S.KARIMOV	Minister, MOH, Uzbekistan, Tashkent, Navoi 123-92, tel.: (3712)41-17-52
Г-н М.ТУРТАЕВ	Начальник Главного Экономического Управления, Министерство Здравоохранения, Узбекистан, Каракалпакстан
Mr. M.TURTAEV	Head of Main Economic Department, Ministry of Health Care, Uzbekistan, Karakalpakstan
Г-н Б.ЮЛДАШЕВ	Заместитель министра, Министерство здравоохранения, Узбекистан, тел.: 41-18-13
Mr. B.YULDASHEV	Deputy Minister, Ministry of Health Care, Uzbekistan, tel.: 41-18-13